

2182

## CERTIFICATE OF DEATH

02103

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>--</b> b. COUNTY <b>--</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Marylander Rest Home</b>		d. STREET ADDRESS <b>1763 Columbia Road, N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Gelia</b> Middle <b>B.</b> Last <b>Allen</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>23,</b> Year <b>19 60</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/4/1874</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Attendance Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DC Public Schools</b>	
11. BIRTHPLACE (State or foreign country) <b>Winchester, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel House</b>		14. MOTHER'S MAIDEN NAME <b>Cecelia C. Belts</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Mrs. Fred Eberz-</b>		Address <b>8604 Garfield Street Bethesda, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>10 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 16, 19 59</b> to <b>Feb-23, 1960</b> that I last saw the deceased alive on <b>February 17, 19 60</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James P. Kerr</b>		ADDRESS (Street, city or town, state) <b>Wannascus, Md.</b> DATE SIGNED <b>2/23/60</b>	
PHYSICIAN'S NAME (Type) <b>James P. Kerr</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/25/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hebron Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Winchester, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.-2901 14th St. N.W.</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 24 '60</b>	
ADDRESS <b>Washington 9, D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1962

Montgomery

Washington, D.C.

The Washington Post Hotel

1962 Washington Road, N.W.

Deceased: E. Allen

Age: 70

84 1870

Residence: Washington, D.C.

Caused by: Cancer

Heart

1962 Washington Road, N.W.

*Handwritten notes and signatures, including "I certify that the above is true and correct."*

*Bottom section containing additional text, possibly a signature or date, and a reference to "The Washington Post Hotel".*

2183

## CERTIFICATE OF DEATH

02110

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY <input checked="" type="checkbox"/>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		
c. LENGTH OF STAY IN 1b <b>36 days</b>			d. STREET ADDRESS <b>5510 First Street, N.W.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bernard Wilson Anthony, Jr.</b>			4. DATE OF DEATH Month Day Year <b>February 17 1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 27, 1959</b>		9. AGE (In years lost birthday) yrs. <b>2</b> Months <b>20</b> Days <b>0</b> Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>	
13. FATHER'S NAME <b>Bernard W. Anthony</b>			14. MOTHER'S MAIDEN NAME <b>Gloria Herron</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>769.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congenital Toxoplasmosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <b>Birth</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 12, 1960</b> , to <b>February 17, 1960</b> , that I last saw the deceased alive on <b>February 17, 1960</b> , and that death occurred at <b>7:50a</b> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Howard M. Kravitz</b>		M.D. <b>The Clinical Center</b>		DATE SIGNED <b>2-17-60</b>	
PHYSICIAN'S NAME (Type) <b>HOWARD M. KRAVITZ, M.D.</b>		ADDRESS (Street, city or town, state) <b>National Institutes of Health Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/20/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bethesda Cemetery</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edwards Funeral Home</b>		ADDRESS <b>Washington</b>		24a. REC'D BY REGISTRAR <b>FEB 23 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Master of Records

Washington

30 days

Postmaster

The City of Chicago, Illinois

January 10, 1920

William

Edward

November 27, 1919

White

Male

None

One

Florida Larson

Edward W. Larson

Chicago Medical Record

None

Announcement

Compendium of Statistics

Birth

January 10, 1920

January 10, 1920

1-10-20

The Chicago Center

Section of Statistics of Health

Edward W. Larson

Edward W. Larson

Chicago Medical Record

Chicago Medical Record



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2116 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02111

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>4 yrs</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>56</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3971 Wendy Lane</u>				d. STREET ADDRESS <u>3971 Wendy Lane</u>			
3. NAME OF DECEASED (Type or print) <u>William Edward Atkinson</u>				4. DATE OF DEATH <u>Feb 28 1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-11-1890</u>	
9. AGE (In years last birthday) <u>69 yrs.</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst Supt. Bolling Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles Atkinson</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Ellis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Margaret Atkinson (wife)</u>				Address <u>Thru 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) } (c) DUE TO <u>(e), stating the underlying cause last.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>2-28-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/2/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Math</u>		22d. LOCATION (City, town, or county) (State) <u>Cal Va</u>	
23. FUNERAL DIRECTOR <u>W. J. Luntzmann &amp; Son</u>				ADDRESS <u>5732</u>			
				24a. REC'D BY REGISTRAR <u>EC</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>	
				DATE <u>MAR 3 '60</u>			

100 200 300 400 500 600 700 800 900 1000

1100 1200 1300 1400 1500 1600 1700 1800 1900 2000

2100 2200 2300 2400 2500 2600 2700 2800 2900 3000

3100 3200 3300 3400 3500 3600 3700 3800 3900 4000

4100 4200 4300 4400 4500 4600 4700 4800 4900 5000

5100 5200 5300 5400 5500 5600 5700 5800 5900 6000

2184

## CERTIFICATE OF DEATH

02112

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Harold</b> Middle <b>Carl</b> Last <b>BARTON</b>				4. DATE OF DEATH Month <b>February</b> Day <b>17</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-25-21</b>	9. AGE (In years lost birthday) <b>38</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Utah</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William BARTON</b>				14. MOTHER'S MAIDEN NAME <b>Isadore Thornton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1940 to DOD</b>		INFORMANT <b>(W) Margaret M. Barton, same as #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, bilateral</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchogenic Carcinoma</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>6 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 15, 19 60</b> , to <b>February 17, 19 60</b> that I last saw the deceased alive on <b>February 17, 19 60</b> , and that death occurred at <b>8:40 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. E. Stitches</b>				ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b>		DATE SIGNED <b>2-18-60</b>	
PHYSICIAN'S NAME (Type) <b>J. E. STITCHER, LT. MC, USN</b>				<b>Bethesda 14, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment 2-20-60</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>Cedar City Utah</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers, 1400 Chapin St., NW, WashDC</b>				24a. REC'D BY REGISTRAR <b>FEB 23 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Robert S. Hays</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

County of ...

State of ...

City of ...

Age ...

Sex ...

Marital Status ...

Occupation ...

Cause of Death ...

Time of Death ...

Place of Death ...

Signature of ...

Date ...

Witness ...

Signature of ...

Date ...

Signature of ...

Date ...

Signature of ...

Date ...

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02113

2185

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Montgomery</b> <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>6 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				e. STREET ADDRESS <b>3219 Decatur Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>Elizabeth</b> Last <b>Belt</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>11</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/24/02x 01</b>		9. AGE (In years last birthday) <b>58 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David B GOTTWALS</b>				14. MOTHER'S MAIDEN NAME <b>Edith Hunt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>M. BELT</b> Address <b>Husband M r. Alvin Same as Above.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2 Congestive heart failure</b> DUE TO <b>Myocardial hyper trophy</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>DUE TO</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic cystic nephropathy + ch. pyelonephritis</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>July 5</b> , 19 <b>60</b> , to <b>11 July</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>10 July</b> , 19 <b>60</b> , and that death occurred at <b>L.A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Horace W. Bernton</b> M.D.		ADDRESS (Street, city or town, state) <b>10511 Summit Ave 17406 Kensington, MD</b>		DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>Horace Bernton</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/13/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GLENWOOD CEMETERY</b>	
22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY INC. SILVER SPRING, MD.</b> <b>Raymond A. Jaska</b>		24a. REC'D BY REGISTRAR <b>FEB 15 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>	

100-1014

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2135

## CERTIFICATE OF DEATH

Reg. Dist. No.

02114

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	c. LENGTH OF STAY IN 1b <u>30 1/2 hrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San &amp; Hospital</u> <u>Washington</u>		d. STREET ADDRESS <u>10001 Raymon Rd</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>FANNIE</u> <u>BINDES</u> <u>BERMAN</u>		4. DATE OF DEATH Month Day Year <u>February 7</u> <u>19 60</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>6-14-84</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Dykstein</u>		14. MOTHER'S MAIDEN NAME <u>(etc)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Jack Ager</u> (etc) Address <u>10001 Raymon Rd. SS.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Diabetes mellitus</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>32 hours</u> <u>7 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>November 1957</u> to <u>February 7, 1960</u> , that I last saw the deceased alive on <u>February 7, 1960</u> , and that death occurred at <u>11:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sydney Leventhal</u>		ADDRESS (Street, city or town, state) <u>9210 Colesville Rd, Silver Spring, Md.</u> DATE SIGNED <u>2/8/60</u>	
PHYSICIAN'S NAME (Type) <u>Sydney Leventhal, M. D.</u>		2210 Colesville Road, Silver Spring, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-9-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Beth Shalom Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. D. Wanzan</u> ADDRESS <u>3501-14 St. N.W.</u>		24a. REC'D BY REGISTRAR <u>FEB 10 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>



## 2117 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>1 month</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2221 LUZERNE AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BELMA</b> Middle <b>BLANCHARD</b> Last		4. DATE OF DEATH Month <b>FEB.</b> Day <b>6</b> Year <b>19 60</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/27/05</b>
9. AGE (In years lost birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MILTON SMITH</b>		14. MOTHER'S MAIDEN NAME <b>SARA DANIELS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>237-14-1394</b>	
17. INFORMANT <b>Mrs. James L. Cambas, 2221 Luzerne Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatoid Arthritis</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/1/59</b> , 19___, to <b>2/6/59</b> , 19___, that I last saw the deceased alive on <b>2/6/59</b> , 19___, and that death occurred at <b>6 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John J. Curry</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>10620 Georgia Ave Silver Spring, Md 2/6/60</b>	
PHYSICIAN'S NAME (Type) <b>JOHN J. CURRY</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/9/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>		22d. LOCATION (City, town, a county) (State) <b>MONTGOMERY COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Pumphrey, Inc.</b>		24a. REC'D BY REGISTRAR <b>FEB 9 '60</b>	
ADDRESS <b>SILVER SPRING, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Birth		Place of Birth		Usual Residence	
Cause of Death		Duration of Illness		Time of Death	
Place of Death		Occupation		Signature of Physician	
Signature of Registrar		Signature of Coroner		Signature of Medical Examiner	

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

2186

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>13 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>57 Bethesda</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5901 Lone Oak Drive</u>				d. STREET ADDRESS <u>1 5901 Lone Oak Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rolland E. Blosser</u>				4. DATE OF DEATH Month Day Year <u>February 16 19 60</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 22, 1887</u>	
9. AGE (In years lost birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mining Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Newcomb Standard, Tennessee</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Isaiah Blosser</u>				14. MOTHER'S MAIDEN NAME <u>Martha Whitcraft</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>WW#1</u>		17. INFORMANT <u>Josephine Blosser-5901 Lone Oak Drive</u>		Address <u>Bethesda, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>anemia from inanition</u> DUE TO (c) <u>carcinoma stomach &amp; metastases</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>Several wks</u> <u>18 mons.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 1959</u> to <u>Feb. 16, 1960</u> , that I last saw the deceased alive on <u>Feb. 15, 1960</u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4700 Bradley Blvd. Chevy Chase, Maryland</u> DATE SIGNED							
ACTUAL SIGNATURE <u>Margaret E. Callan</u> M.D.				PHYSICIAN'S NAME (Type) <u>Margaret E. Callan, M.D.</u>			
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/19/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. 2901 14th St. N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

Date: 11/11/2011

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THE UNIVERSITY OF CHICAGO PRESS



2187

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>51 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <b>2 D Gardenway</b>							
3. NAME OF DECEASED (Type or print) First <b>Michael</b> Middle <b>Dix</b> Last <b>Boone</b>		4. DATE OF DEATH Month <b>February</b> Day <b>8</b> Year <b>1960</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 10, 1948</b>	9. AGE (In years last birthday) <b>11</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Dix C. Boone</b>				14. MOTHER'S MAIDEN NAME <b>Helen Crowley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure &amp; hypotension</b> DUE TO 196.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Osteogenic Sarcoma</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>1 year</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 19, 1959</b> , to <b>February 8, 1960</b> , that I last saw the deceased alive on <b>February 8, 1960</b> , and that death occurred at <b>12:10 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles E. Mengel</b>				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>2-8-60</b>			
PHYSICIAN'S NAME (Type) <b>Charles E. Mengel, M.D.</b>				National Institutes of Health <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Feb. 11, 1960</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Chambers</b> ADDRESS <b>CO. Riverdale Md.</b>				24a. REC'D BY REGISTRAR <b>FEB 10 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS COLLEGE OF DENTISTRY

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

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*The D. B. Cooper*

06-11-2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2188

CERTIFICATE OF DEATH

Reg. Dist. No.

02118

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN 1b <b>53 hr. 1 min.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fulton School Road</b> d. STREET ADDRESS <b>Pendle School Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Baby</b> First <b>Boy</b> Middle <b>Boswell</b> Last		4. DATE OF DEATH Month <b>February</b> Day <b>21</b> Year <b>1960</b>					
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 18, 1960</b>	9. AGE (In years last birthday) <b>2</b> yrs.	IF UNDER 1 YEAR Months <b>2</b> Days <b>53</b> Hours <b>1</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Anthony L. Boswell Jr.</b>			14. MOTHER'S MAIDEN NAME <b>Martha Clara Simons</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <b>Martha C. Boswell</b> Address <b>Pendle School Road Fulton, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial hemorrhage (rt. temporal region)</b> <b>760.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity (one of twins)</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>2/18</b> , 19 <b>60</b> , to <b>2/21</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>2/21</b> , 19 <b>60</b> , and that death occurred at <b>3:00 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>Charles S. Whitaker</b> , M.D. PHYSICIAN'S NAME (Type) <b>Charles S. Whitaker, M.D.</b> <b>Clarksville, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/22/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Louis Cemetery</b>			
22d. LOCATION (City, town, or county) (State) <b>Clarksville Md</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Connelldon, Laurel, Md</b> ADDRESS _____ 24a. REC'D BY REGISTRAR DATE <b>FEB 24 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kious</b>					

2173161XV2

STATE OF TEXAS  
COUNTY OF DALLAS

Know all men by these presents, that I, the undersigned, for and in consideration of the sum of \$100.00 to me in hand paid by the said Baby, the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said Baby, all that certain

tract of land, situate in the County of Dallas, State of Texas, and being more particularly described as follows, to-wit:

Section 34, Township 10N, Range 14E, County of Dallas, State of Texas, containing 40.00 acres of land.

Witness my hand and seal of office this 10th day of January, 1900.

Notary Public in and for the State of Texas.

(Signature of Notary)

Subscribed and sworn to before me this 10th day of January, 1900.

Notary Public in and for the State of Texas.

2189

CERTIFICATE OF DEATH

Reg. Dist. No.

02119

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>19 hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Moses</b> Middle <b>Eli</b> Last <b>Boyd</b>		4. DATE OF DEATH Month <b>February</b> Day <b>9</b> Year <b>19 60</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>N negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 8, 1880</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>day laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Boyd</b>		14. MOTHER'S MAIDEN NAME <b>Rachel Prather</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>yes</b>	
17. INFORMANT <b>Rachel Macabee 9404 Kansas Ave; Silver Spring daughter</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia Bilateral Bronchite 5 days</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 8</b> , 19 <b>60</b> , to <b>Feb 9</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>FEB 9</b> , 19 <b>60</b> , and that death occurred at <b>2:45</b> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>P.P. Andrews</b> M.D. <b>4201 Fessenden St NW 2-9-60</b> PHYSICIAN'S NAME (Type) <b>P.P. ANDREWS</b> <b>Washington D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/14/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ash Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Sandy Spring, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Sumner</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 15 '60</b>	
ADDRESS <b>Rockville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

1815

**Figure 1**

2004

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02120

Reg. Dist. No.

2136

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mnty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. &amp; Hosp</u>		d. STREET ADDRESS <u>1816 Richmond Cuz</u>	
3. NAME OF DECEASED (Type or print) <u>Henry J. Brandlein</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 13, 1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet maker</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Christian Brandlein</u>		14. MOTHER'S MAIDEN NAME <u>Francesca Fickert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>100-07-9423</u>	
17. INFORMANT <u>Mrs. Pearl E. Brandlein, 816 Richmond Ave.</u>		Address <u>Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschaw</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschaw</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/22/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>Raymond A. Ziska</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Hous</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12-30

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE  
HOURS

1. Name of Deceased: \_\_\_\_\_

2. Sex: ☐ Male ☐ Female

3. Age: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Place of Birth: \_\_\_\_\_

6. Usual Residence: \_\_\_\_\_

7. Date of Death: \_\_\_\_\_

8. Time of Death: \_\_\_\_\_

9. Place of Death: \_\_\_\_\_

10. Cause of Death: \_\_\_\_\_

11. Manner of Death: \_\_\_\_\_

12. Signature of Medical Examiner: \_\_\_\_\_

13. Signature of Coroner: \_\_\_\_\_

14. Signature of Registrar: \_\_\_\_\_

15. Signature of Physician: \_\_\_\_\_

16. Signature of Nurse: \_\_\_\_\_

17. Signature of Family Member: \_\_\_\_\_

18. Signature of Other: \_\_\_\_\_

19. Signature of Other: \_\_\_\_\_

20. Signature of Other: \_\_\_\_\_

21. Signature of Other: \_\_\_\_\_

22. Signature of Other: \_\_\_\_\_

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99. Signature of Other: \_\_\_\_\_

100. Signature of Other: \_\_\_\_\_

## CERTIFICATE OF DEATH

Reg. Dist. No.

02121

2190

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>84 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington 16 (Westgate, Md.)</b> d. STREET ADDRESS <b>5011 Jamestown Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Nancy Groom Bream</b>			4. DATE OF DEATH Month Day Year <b>February 26 1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 21, 1920</b>	9. AGE (In years last birthday) <b>39 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>5 Mon. 2 1/2 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Technician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laboratory</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>Claudius Murchison</b>		
14. MOTHER'S MAIDEN NAME <b>Constance Waterman</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		
16. SOCIAL SECURITY NO. <b>Unascertainable</b>			17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO <b>170X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diffuse Carcinomatous</b> DUE TO <b>Carcinoma of Breast</b> (c) <b>2 1/2 yrs.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 yrs.</b>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1:05 p.m.</b>	
20f. (City or town) <b>Bethesda</b>		20g. (County) <b>Montgomery</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>December 4, 1959</b> , to <b>February 26, 1960</b> , that I last saw the deceased alive on <b>February 26, 1960</b> , and that death occurred at <b>1:05 p.m.</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Louis V. Aviola</b>		M.D. <b>LOUIS V. AVIOLI, M.D.</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center National Institutes of Health Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/1/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem. - Arlington, Virginia</b>	
22d. LOCATION (City, town, or county) <b>Wash. D.C.</b>		22e. (State) <b>D.C.</b>		22f. (County) <b>Dist. of Columbia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. - 2901 14th St., N.W.</b>		ADDRESS <b>Wash. D.C.</b>		24a. REC'D BY REGISTRAR <b>FEB 29 1960</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2199

Residence of Deceased

Age

Washington, D.C.

31 days

2011 is a common year

2011 is a common year

2011 is a common year

2011 is a common year

2011 is a common year

2011 is a common year

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2167

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02122

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. LENGTH OF STAY IN lb <b>Since Sept. 1959 56 SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENSINGTON GARDENS REST HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>H.</b> Middle <b>ALBERT</b> Last <b>BUEHLER</b>		4. DATE OF DEATH Month <b>Feb</b> Day <b>15</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/19/73</b>
9. AGE (In years lost birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grocer (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Owner of Grocery Store</b>	
11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRIEDRICH BUEHLER</b>		14. MOTHER'S MAIDEN NAME <b>KAROLINE GOLDNER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mrs. Alma B. Schaeffer, 1613 Oaklawn Ct.</b>		Address <b>Silver Spring, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Senile Arteriosclerosis</b> (b) <b>7 days</b> (c) <b>10 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Apr</b> , 19 <b>46</b> , to <b>15 Feb</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>12 Feb</b> , 19 <b>60</b> , and that death occurred at <b>1:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7112 Willow Hwa</b> DATE SIGNED <b>15 Feb 1960</b> ACTUAL SIGNATURE <b>M. B. Queen</b> M.D. <b>Takoma Park, Md.</b> PHYSICIAN'S NAME (Type) <b>M. B. QUEEN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	22b. DATE THEREOF <b>2/18/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CREMATORY</b>	22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond W. Ziska</b>		24a. REC'D BY REGISTRAR <b>FEB 17 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Date of registration	



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14 Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Lerch Callan</u>		4. DATE OF DEATH <u>Feb 6 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/81</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>8</u> Hours <u>15</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>John B. Lerch</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Lepper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Eleanor C. Craun, Bethesda, Md</u>		Address <u>Bethesda, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY HEMORRHAGE</u> 4341 DUE TO <u>PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CON. HEART FAILURE Comp.</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN 8, 1960</u> , to <u>FEB 13, 1960</u> , that I last saw the deceased alive on <u>2/3</u> , 19 <u>60</u> , and that death occurred at <u>4:58</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. J. Brennan</u>		ADDRESS (Street, city or town, state) <u>Bethesda, Md</u>	
PHYSICIAN'S NAME (Type) <u>A. J. BRENNAN</u>		DATE SIGNED <u>2/16/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>At home</u>	22b. DATE THEREOF <u>Feb 10, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. A. Saffell</u>		24. REG'D. BY REGISTRAR <u>FEB 10 1960</u>	
ADDRESS <u>475 H. A. N.Y. N.Y.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

ROYALTY STATE DEPARTMENT OF HEALTH - BATHING, 18

See Div. 11a

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15, 1900</i>		5. PLACE OF BIRTH <i>John Doe, Pa.</i>	
6. OCCUPATION <i>Teacher</i>		7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>Jan 1, 1925</i>		9. PLACE OF MARRIAGE <i>John Doe, Pa.</i>		10. DATE OF DEATH <i>Jan 10, 1945</i>	
11. PLACE OF DEATH <i>John Doe, Pa.</i>		12. CAUSE OF DEATH <i>Heart Disease</i>		13. DISEASE OR INJURY <i>Heart Disease</i>		14. MEDICAL HISTORY <i>None</i>		15. SIGNATURE OF PHYSICIAN <i>John Doe, M.D.</i>	
16. SIGNATURE OF REGISTRAR <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>		19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BATHING, 18, AND A COPY OF IT IS TO BE FURNISHED TO THE FAMILY OF THE DECEASED. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT IT IS SIGNED BY A PHYSICIAN OR A WITNESS. IT IS THE DUTY OF THE PHYSICIAN OR WITNESS TO SIGN THIS CERTIFICATE CORRECTLY AND TO FURNISH A COPY OF IT TO THE REGISTRAR. IT IS THE DUTY OF THE FAMILY OF THE DECEASED TO FURNISH A COPY OF THIS CERTIFICATE TO THE REGISTRAR. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT IT IS SIGNED BY A PHYSICIAN OR A WITNESS. IT IS THE DUTY OF THE PHYSICIAN OR WITNESS TO SIGN THIS CERTIFICATE CORRECTLY AND TO FURNISH A COPY OF IT TO THE REGISTRAR. IT IS THE DUTY OF THE FAMILY OF THE DECEASED TO FURNISH A COPY OF THIS CERTIFICATE TO THE REGISTRAR.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2168

## CERTIFICATE OF DEATH

Reg. Dist. No.

02124

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b <b>one week</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Sanit.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mamie</b> Middle <b>ELIZABETH</b> Last <b>Chase</b>		4. DATE OF DEATH Month <b>February</b> Day <b>11</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Sep 9, 1872</b>
9. AGE (In years last birthday) yrs. <b>87</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Assessor's office Rockville, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>Trenton, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JEFFERSON C. POWERS</b>		14. MOTHER'S MAIDEN NAME <b>MARY ELY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
INFORMANT Address <b>Mr. Ben Shaw, 21 Shaw Ave., Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Respiratory Infection</b> 4344 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic debilitation</b> DUE TO (c) <b>Chronic heart failure, compensated</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 26</b> , 19 <b>60</b> , to <b>Feb 1</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Feb 1</b> , 19 <b>60</b> and that death occurred at <b>11:35 am</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert T. Thibadeau</b>		ADDRESS (Street, city or town, state) <b>10609 Concord Street</b> DATE SIGNED <b>Feb 1, 1960</b>	
PHYSICIAN'S NAME (Type) <b>Robert T. Thibadeau, M.D.</b>		<b>Kensington, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2/4/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>GLENWOOD CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. BUMPNEY, INC.</b> <b>Raymond A. Ziska</b>		24a. REC'D BY REGISTRAR <b>SILVER SPRING, MD.</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the registrar within 72 hours after death.

CERTIFICATE OF DEATH

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2192

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>				c. LENGTH OF STAY IN 1b <b>7 DAYS</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHITE OAK</b>				d. STREET ADDRESS <b>RT. #2 STEWART LANE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <b>RUTH ROSETTA CHRISTIAN</b>				4. DATE OF DEATH Month Day Year <b>FEBRUARY 12 19 60</b>				5. SEX <b>FEMALE</b>				6. COLOR OR RACE <b>NEGRO</b>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>3/15/04</b>				9. AGE (In years last birthday) <b>55</b> yrs.				IF UNDER 1 YEAR Months Days Hours Min.				IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>CHARLES HENRY JACKSON</b>				14. MOTHER'S MAIDEN NAME <b>CINDERELLA JACKSON</b>															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)				INFORMANT <b>HOSPITAL RECORDS</b>				Address <b>OLNEY, MD.</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF CERVIX WITH METASTASES</b> DUE TO 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)															
21. I certify that I attended the deceased from <b>FEB. 5</b> , 19 <b>60</b> , to <b>FEB. 12</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>FEB. 12</b> , 19 <b>60</b> , and that death occurred at <b>4:30 P.M.</b> , from the causes and on the date stated above.																ADDRESS (Street, city or town, state)				DATE SIGNED <b>2/13/60</b>															
ACTUAL SIGNATURE <i>[Signature]</i>				M.D. <i>[Signature]</i>				PHYSICIAN'S NAME (Type) <b>C. H. LIGON, M. D.</b>				SANDY SPRING, MARYLAND																							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>2/15/60</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Park..</b>				22d. LOCATION (City, town, or county) (State) <b>Rockville, Md.</b>																							
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Surnden</i>				ADDRESS <b>Rockville, Md.</b>				24a. REC'D BY REGISTRAR <b>FEB 18 '60</b>				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>																							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2105

DECEASED'S NAME

LAST NAME

FIRST NAME

MIDDLE NAME

DATE OF BIRTH

PLACE OF BIRTH

SEX

DATE OF DEATH

PLACE OF DEATH

COUNTY

DATE OF DEATH

CAUSE OF DEATH

MODE OF DEATH

NOTES

AGE

SEX

DECEASED'S NAME

DECEASED'S NAME

VIRGINIA

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2137

## CERTIFICATE OF DEATH

Reg. Dist. No.

02126

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Harvey</u> Last <u>Clark</u>		4. DATE OF DEATH Month <u>February</u> Day <u>16</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-8-96</u>
9. AGE (In years lost birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Clark</u>		14. MOTHER'S MAIDEN NAME <u>Laura Goddard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Wife - Mrs. Margaret Clark - same as above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized peritonitis</u> DUE TO <u>two recently perforated gastric ulcers.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>congestive cardiac failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary sclerosis with occlusion; myocardial insufficiency</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>10 days</u> <u>18 hours</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov.</u> , 19 <u>58</u> , to <u>FEB 16</u> , 19 <u>60</u> that I last saw the deceased alive on <u>FEB 16</u> , 19 <u>60</u> , and that death occurred at <u>6:40</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert K. Krichmar</u>		ADDRESS (Street, city or town, state) <u>7733 ALASKA AVE NW WASH 12 D.C.</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT K. KRICHMAR</u>		DATE SIGNED <u>FEB 17 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2/19/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	22d. LOCATION (City, town, or county) (State) <u>Montgomery Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. 1400 Chapin St NW</u>		24b. REGISTRAR'S SIGNATURE <u>Catherine E. Kenna</u>	
ADDRESS <u>1400 Chapin St NW</u>		DATE <u>FEB 18 1960</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

1

050

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2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2193

CERTIFICATE OF DEATH

Reg. Dist. No.

02127

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Ridley Park</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN lb <b>48 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Benjamin</b> Middle <b>Frank</b> Last <b>Colten, Sr.</b>				4. DATE OF DEATH Month <b>February</b> Day <b>26</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 3, 1877</b>	
9. AGE (In years last birthday) <b>82</b>		10. IF UNDER 1 YEAR Months <b>82</b>		11. IF UNDER 24 HRS. Days <b>82</b>		12. IF UNDER 24 HRS. Hours <b>82</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sexton &amp; Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>			
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Benjamin S. Colten</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Rhodes</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>196-14-4102</b>			
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhagic Broncho-Pneumonia</b> DUE TO <b>199.2</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic Chondrosarcoma</b> DUE TO (c) <b>1 Year</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>January 9, 1960</b> , to <b>February 26, 1960</b> that I last saw the deceased alive on <b>February 26, 1960</b> , and that death occurred at <b>7:00 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Saul Genuth</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>			
DATE SIGNED <b>2-27-60</b>							
PHYSICIAN'S NAME (Type) <b>SAUL GENUTH, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/1/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union Presbyterian Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Kirkwood, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co.</b> ADDRESS <b>2901 14th St. N.W., Washington, D.C.</b>				24a. REC'D BY REGISTRAR <b>MAR 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

2007/08/08

121. *Br. nigrescens* (Gmelin) Fernald, 1907

• •

1992

222

1997-1998 • 8. 2000-2001

Figure 1. The effect of the concentration of the solution on the rate of the reaction.

1

• **Open Access**

W. W. W.

• *Sci. agric. (Campesinato)* 1993, 56(1): 1-10.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Montgomery Co., Deputy Medical Examiner notified.

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY				a. STATE			
Montgomery MARYLAND				Virginia b. COUNTY Arlington ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Bethesda (Rural)		44 days		Arlington 83x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
U. S. Naval Hospital				4439 N. 17th Street			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First Middle Last				Month Day Year			
William Edward CORFITZEN				February 4 19 60			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Male		Caucasian		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2-4-08	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
52 yrs.		Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Foreign Service				U. S. Govt.		New York	
12. CITIZEN OF WHAT COUNTRY?				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Edward CORFITZEN				Theresa KEEGAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
No							
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				INFORMANT Address			
No				(W) Regina D. Corfitzen, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia							
357x DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Syringomyelia							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
Fracture of Left Hip							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fell while walking at home. Fall was due to instability caused by his central nervous system disease.							
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
Hour a. m. 3:25 p. m. 11/20/ 1959				While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		Home Arlington Virginia	
21. I certify that I attended the deceased from December 22, 19 59, to February 4, 19 60, that I last saw the deceased alive on February 3, 19 60, and that death occurred at 2:00A, from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank J. Dawson II.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) F. J. DAWSON II, LT, MC, USN				Bethesda 14, Md. 2-4-60			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		2-8-60		Columbia Gardens		Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Joseph Gawler's & Sons				FEB 8 '60		C. J. Thayer	
Hos. Gawler's & Sons, 1756 Pa. Ave., NW, WashDC							

2194 CERTIFICATE OF DEATH

Reg. Dist. No.

02128  
215



Dr. Taylor's Home, 1750 St. Ave., N.W., Washing

Colorado Springs

Arlington

Dr. E. E. Taylor, M.D., M.P.H., U.S.N.

Bethesda, Md., D.C.

U. S. Naval Hospital

2-7-50

February 7, 1950

December 22, 1949

2:00

Home

Arlington

Virginia

caused by his central nervous system disease.

Left while walking at home. Will see the neurologist

fracture of left hip

Syracuse

Memphis

(W) Regina J. Corbitt, same as above

Thomas Nelson

New York

USA

Canadian

2-4-50

52

Edward

Corbitt

Foot

4439 N. 17th Street

U. S. Naval Hospital

Rebecca (Hill)

44 days

Arlington

Arlington

Virginia

Memphis

CERTIFICATE OF DEATH

2102

210



2195

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>33 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47 X - 3</b> d. STREET ADDRESS <b>3023 14th St., N.W. - Apt. 713</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>FRANCES SHEERS CRAMER</b>				4. DATE OF DEATH Month Day Year <b>February 11 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-16-93</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stenographer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>		11. BIRTHPLACE (State or foreign country) <b>Connecticut</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Samuel SHEERS</b>				14. MOTHER'S MAIDEN NAME <b>Rosaland BURKO</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>(H) J. A. Cramer, same as #2 above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia, nephrosclerosis</b> <b>260 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes mellitus</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Peripheral Vascular disease to gangrene AS HD</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 9</b> , 19 <b>60</b> , to <b>February 11</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>February 11</b> , 19 <b>60</b> , and that death occurred at <b>2:20 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>R. G. Galbraith Jr.</b> M.D. <b>U. S. Naval Hospital</b> <b>2-11-60</b>							
ACTUAL SIGNATURE <b>R. G. GALBRAITH, JR., LT, MC, USN</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>2-13-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. H. Hines</b>				ADDRESS <b>2901 14th St. NW, WashDC</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 15 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Director of Consular

Washington

3021 14th St., N.W., Apt. 113

January 11

1-11-33

Connecticut

U.S.A.

Newland Bldg.

(H) J. A. O'Connor, same as above

33 days

STANLEY

x

U. S. Govt.

Home

Bochoda (Rural)

U. S. Naval Hospital

STANLEY

Connecticut

Bochoda

Bochoda

Home

## CERTIFICATE OF DEATH

Reg. Dist. No.

02130

2195

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLARKSBURG</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CLARKSBURG</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CLARKSBURG RT 1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JDA JANE CRANFORD</u>				4. DATE OF DEATH Month Day Year <u>2 8 1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 31 1879</u>	9. AGE (In years lost birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ind</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>THOMAS E. MOXLEY</u>				14. MOTHER'S MAIDEN NAME <u>ANNA RILEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>155.1</u>		INFORMANT <u>HORACE WILLIAMS FREDERICK MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CANCER OF LIVER</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PRIMARY CANCER OF GALL BLADDER</u> DUE TO (c) <u>OBILILE DUCTS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 5</u> , 19 <u>57</u> , to <u>Feb 8</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 7</u> , 19 <u>60</u> , and that death occurred at <u>6:25 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edmeator WO</u>				ADDRESS (Street, city or town, state) <u>MAIN STREET</u>			
DATE SIGNED <u>2/8/60</u>							
PHYSICIAN'S NAME (Type) <u>G.F. MEADORS, MD</u>				DAMASCUS, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/10/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVE</u>		22d. LOCATION (City, town, or county) (State) <u>FREDERICK MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clarence C. Early</u>		ADDRESS <u>FREDERICK MD</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08130

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of Albany City of Albany

On the 12 day of April 1942

at Albany New York

I, John J. Connelley

being a duly qualified and licensed

physician, do hereby certify that

John J. Connelley

was born on the 12 day of April 1942

at Albany New York

and died on the 12 day of April 1942

at Albany New York

of the disease of Heart Disease

and the cause of death was Heart Disease

and the manner of death was Natural

and the death was Not due to

any of the causes mentioned in

Section 2625 of the Laws of 1939

and the death was Not due to

any of the causes mentioned in

Section 2625 of the Laws of 1939

JOHN J. CONNELLEY

1. X

M

X

1

20 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4c may be retained by the hospital or attending physician.

20 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2197

CERTIFICATE OF DEATH

Reg. Dist. No.

02131

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FOREST GLEN</b> c. LENGTH OF STAY IN lb <b>since 1917</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9805 ROSENSTEEL AVE.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FOREST GLEN</b> d. STREET ADDRESS <b>9805 ROSENSTEEL AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ETHEL</b> Middle <b>MARIE</b> Last <b>CULVER</b>			4. DATE OF DEATH Month <b>FEB.</b> Day <b>5</b> Year <b>19 60</b>				
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/9/98</b>	9. AGE (In years last birthday) yrs. <b>61</b>	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>GEORGE HENRY CULVER</b>				
14. MOTHER'S MAIDEN NAME <b>CAROLINE DOROTHY CULVER GRAF</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				
16. SOCIAL SECURITY NO. <b>NONE</b>			17. INFORMANT <b>Mr. F. Earl Culver, 3006 Homewood Pkwy. Kensington, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uterine due to Carcinoma of Cervix Uteris with local metastases</b> 171X DUE TO (b) <b>6 months</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>October 1, 1959</b> to <b>February 5, 1960</b> that I last saw the deceased alive on <b>Feb 5, 1960</b> , and that death occurred at <b>3:39 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10670 Georgia Ave Silver Spring, Md</b> DATE SIGNED <b>2/6/60</b>							
ACTUAL SIGNATURE <b>John J. Curry</b> PHYSICIAN'S NAME (Type) <b>JOHN J. CURRY</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 22b. DATE THEREOF <b>2/8/60</b> 22c. NAME OF CEMETERY OR CREMATORY <b>ST. JOHN'S CATH. CEMETERY</b> 22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MD.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 9 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>			

CERTIFICATE OF DEATH

2191

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible] DATE OF BIRTH: [illegible]

RESIDENCE: [illegible] OCCUPATION: [illegible] CAUSE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible] SIGNATURE OF PHYSICIAN: [illegible]

SIGNATURE OF REGISTRAR: [illegible] OFFICE OF VITALS: [illegible]

DATE OF REGISTRATION: [illegible] PLACE OF REGISTRATION: [illegible]

NAME OF WITNESSES: [illegible] SIGNATURES: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

SIGNATURE OF PHYSICIAN: [illegible] SIGNATURE OF REGISTRAR: [illegible]

OFFICE OF VITALS: [illegible] DATE OF REGISTRATION: [illegible]

PLACE OF REGISTRATION: [illegible] NAME OF WITNESSES: [illegible]

SIGNATURES: [illegible] DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible] SIGNATURE OF PHYSICIAN: [illegible]

SIGNATURE OF REGISTRAR: [illegible] OFFICE OF VITALS: [illegible]

DATE OF REGISTRATION: [illegible] PLACE OF REGISTRATION: [illegible]

NAME OF WITNESSES: [illegible] SIGNATURES: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

SIGNATURE OF PHYSICIAN: [illegible] SIGNATURE OF REGISTRAR: [illegible]

OFFICE OF VITALS: [illegible] DATE OF REGISTRATION: [illegible]

PLACE OF REGISTRATION: [illegible] NAME OF WITNESSES: [illegible]

SIGNATURES: [illegible] DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible] SIGNATURE OF PHYSICIAN: [illegible]

SIGNATURE OF REGISTRAR: [illegible] OFFICE OF VITALS: [illegible]

DATE OF REGISTRATION: [illegible] PLACE OF REGISTRATION: [illegible]

NAME OF WITNESSES: [illegible] SIGNATURES: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

SIGNATURE OF PHYSICIAN: [illegible] SIGNATURE OF REGISTRAR: [illegible]

OFFICE OF VITALS: [illegible] DATE OF REGISTRATION: [illegible]

PLACE OF REGISTRATION: [illegible] NAME OF WITNESSES: [illegible]

SIGNATURES: [illegible] DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible] SIGNATURE OF PHYSICIAN: [illegible]



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2198

CERTIFICATE OF DEATH

Reg. Dist. No. 215

02132

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>156 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Ranier</b> 1647-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>4504 31st Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Orion</b> Middle <b>Lee</b> Last <b>CURTIS</b>		4. DATE OF DEATH Month <b>February</b> Day <b>12</b> Year <b>1960</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-4-95</b>		9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Policeman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, DC Police</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James CURTIS</b>				14. MOTHER'S MAIDEN NAME <b>Alice Kempel</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>579-40-4807</b>		INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> 583X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Post necrotic Cirrhosis</b> DUE TO (c) <b>Hepatitis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>3 years</b> <b>Jan 1955</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 9, 1959</b> to <b>February 12, 1960</b> , that I last saw the deceased alive on <b>February 11, 1960</b> , and that death occurred at <b>2:30A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>John Wood Davis</i>		M.D.		ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b>		DATE SIGNED <b>2-12-60</b>	
PHYSICIAN'S NAME (Type) <b>John Wood DAVIS, LT, MC, USN</b>		<b>Bethesda 14, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-15-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>S. H. Hines Co.</i>				ADDRESS <b>S. H. Hines Co., 2901 14th St., NW, Washington, DC</b>		24a. REC'D BY REGISTRAR <b>FEB 15 '60</b>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>			

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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U.S. GOVERNMENT PRINTING OFFICE: 1965

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02133

2199

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>10 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>57 Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8709 - Grant St.</u>				d. STREET ADDRESS <u>8709 Grant St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>E.</u> Last <u>Danhahl</u>				4. DATE OF DEATH Month <u>2</u> - Day <u>7</u> - Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-23-1882</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>		13. FATHER'S NAME <u>John Frebert</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Seibert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>John G. Danhahl</u> Address <u>8709 Grant St Bethesda, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADAMS-STOKES SYNDROME</u> <u>433.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>433.0</u> DUE TO (c) <u>433.0</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>congestive heart failure (440)</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>—</u> <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u>				20g. (County) <u>—</u>		20h. (State) <u>—</u>	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>7/7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7/7</u> , 19 <u>60</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>D. J. Brennan</u> M.D.				ADDRESS (Street, city or town, state) <u>Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>A. J. BRENNAN</u>				DATE SIGNED <u>—</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/10/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Geiers Sons Co</u>				ADDRESS <u>3605-14 St NW Wash, D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 11 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							



TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2177 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02134

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>9 yr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>521 W. Montgomery Ave</u>				d. STREET ADDRESS <u>1521 W. Montgomery Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frank Isaac Davis</u>				4. DATE OF DEATH <u>Feb 7 1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 4 1885</u>		9. AGE (In years last birthday) <u>74 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>County official</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Horace Davis</u>				14. MOTHER'S MAIDEN NAME <u>Emma Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-38-7502</u>		17. INFORMANT <u>Susie Davis (wife) Stein</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> DUE TO <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Feb 7, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/10/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Beallsville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>FEB 9 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			







2200

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jesse</b> Middle <b>Hood</b> Last <b>Davis</b>		4. DATE OF DEATH Month <b>2</b> Day <b>17</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/7/74</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	11. BIRTHPLACE (State or foreign country) <b>Arkansas</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Thomas Jefferson Davis</b>	
14. MOTHER'S MAIDEN NAME <b>Martha Ann Hood</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mrs. Demaris Davis Hearn</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Septicemia</b> <b>692.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Severe cellulitis rt. face</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(1) Arteriosclerosis General (2) Bronchiectasis, severe</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>10 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 17, 1960</b> , to <b>Feb 17, 1960</b> , that I last saw the deceased alive on <b>Feb 17, 1960</b> , and that death occurred at <b>11:30 a.m.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stewart Clapp</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>3921 Ingomar St. N.W. 2/17/60</b>	
PHYSICIAN'S NAME (Type) <b>Stewart Clapp</b>		<b>Wash 15 D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/19/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>FEB 23 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Hearn</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

3200

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

2178

CERTIFICATE OF DEATH

Reg. Dist. No.

02136

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>				c. LENGTH OF STAY IN 1b <b>32 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>106 S. Adams Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Walter Thomas Davis</b>				4. DATE OF DEATH Month Day Year <b>February 10 19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 28, 1881</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>George W. Davis</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Price</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-32-1885</b>			
17. INFORMANT <b>Mary S. Davis-Wife-same as 2d</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage, right</b> <b>331X</b> DUE TO <b>hemiplegia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO (c) <b>10 days</b> <b>5 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>No</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>19 30</b> 19 <b>1960</b> , that I last saw the deceased alive on <b>February 9, 19 60</b> , and that death occurred at <b>2 15 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>110 S. Washington St. Rockville, Montg Co., Md.</b> DATE SIGNED <b>2/10/60</b>							
ACTUAL SIGNATURE <b>W. A. Linthicum</b>				PHYSICIAN'S NAME (Type) <b>William A. Linthicum</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/12/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				24a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>				DATE <b>FEB 11 '60</b>			

# CERTIFICATE OF DEATH

2178



Rockville

2178

Rockville

Rockville

2178

Rockville

106 2. Adams Street

106 2. Adams Street

William Thomas Davis

April 20, 1901

Rockville

Rockville

Rockville

Rockville

Rockville

Rockville

Rockville

Rockville

Rockville

Rockville

Rockville

Rockville

Rockville

Rockville

## 2169 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON, MD.</b>		c. LENGTH OF STAY IN 1b <b>1 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10018-FREDERICK AVENUE, KENSINGTON, MD.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>May Hastings Dickinson</b>		4. DATE OF DEATH <b>February 14 1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/19/1865</b>
9. AGE (In years last birthday) <b>94</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MONTCLAIR, NEW JERSEY</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>TYRUS CASS</b>		14. MOTHER'S MAIDEN NAME <b>MARY MILLARD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>KENSINGTON, MARYLAND</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abdominal Hemorrhage</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of Colon</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>Acute</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 19, 1959</b> , to <b>Feb. 14, 1960</b> , that I last saw the deceased alive on <b>Feb. 13, 1960</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. B. Little</b>		ADDRESS (Street, city or town, state) <b>6911 5th St. NW Wash. DC.</b> DATE SIGNED <b>2/14/60</b>	
PHYSICIAN'S NAME (Type) <b>A. B. LITTLE, MD</b>		6911- 5th STREET, N.W.-WASH. D.C. 2/14/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/17/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>TROY, NEW YORK</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>MARTIN W. HYSOING CO. 1300 N. STREET, N.W.-WASH. D.C.</b>		24a. REC'D BY REGISTRAR <b>FEB 17 '60</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26



MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/5B

2133 - CERTIFICATE OF DEATH

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may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02139

CERTIFICATE OF DEATH

Reg. Dist. No.

2201

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>21 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>South Carolina</b> b. COUNTY <b>Marietta</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Route #4</b> d. STREET ADDRESS <b>77x-3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Fred</b> Middle <b>Henry</b> Last <b>Dunn</b>			4. DATE OF DEATH Month <b>February</b> Day <b>7</b> Year <b>19 60</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>August 6, 1902</b>		9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>2</b> Hours <b>0</b> Min.			
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>		13. BIRTHPLACE (State or foreign country) <b>South Carolina</b>			
14. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		15. FATHER'S NAME <b>William H. Dunn</b>					
16. MOTHER'S MAIDEN NAME <b>Florence McGaha</b>		17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					
18. SOCIAL SECURITY NO. <b>Unascertainable</b>		19. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>					
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastro-Intestinal Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Stomach Ulcer</b> DUE TO (c) <b>Pulmonary Infarcts, Aortic Stenosis</b>							
21. INTERVAL BETWEEN ONSET AND DEATH <b>1-2-days</b> <b>? weeks</b>							
22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Infarcts, Aortic Stenosis</b>							
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		23b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
24a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		24b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		24c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Greenville</b>			
24d. (City or town) <b>Greenville</b>		24e. (County) <b>SC</b>		24f. (State) <b>SC</b>			
25. I certify that I attended the deceased from <b>January 17, 1960</b> , to <b>February 7, 1960</b> that I last saw the deceased alive on <b>February 7, 1960</b> , and that death occurred at <b>10:35 A.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>2-7-60</b>							
ACTUAL SIGNATURE <b>Charles A. Chidsey</b>		M.D. <b>The Clinical Center</b>					
PHYSICIAN'S NAME (Type) <b>CHARLES A. CHIDSEY, M.D.</b>		National Institutes of Health <b>Bethesda 14, Maryland</b>					
26a. BURIAL, CREMATION, REMOVAL (Specify) <b>210/60</b>		26b. DATE THEREOF <b>2/10/60</b>		26c. NAME OF CEMETERY OR CREMATORY <b>Greenville</b>			
26d. LOCATION (City, town, or county) <b>Greenville</b>		26e. (State) <b>SC</b>		26f. (State) <b>SC</b>			
27. FUNERAL DIRECTOR'S SIGNATURE <b>Ching Chong Funeral Home</b>		ADDRESS <b>5190 St. Anne Ave</b>		28. REC'D BY REGISTRAR <b>FEB 10 '60</b>			
29. REGISTRAR'S SIGNATURE <b>Arthur S. Rouse</b>		30. REGISTRAR'S SIGNATURE <b>Arthur S. Rouse</b>					

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

South Carolina

Charleston

Age 21 days

Female

The Clinical Center, Charleston, S.C.

January 7

1950

January 6, 1950

South Carolina

Charleston

Flourish Hobbs

The Medical Record

Presbyterian The Medical Center, Charleston, S.C.

Electro-Infusional Hemorrhage

1-3-50

Stomach Ulcer

2 weeks

Physician, Assistant, Arthur S. Semon

January 7 1950

10:30A

February 7

2-7-50

The Clinical Center

National Institution of Health

Charleston, S.C.

Charles A. Semon

CHARLES A. SEMON

Physician

THE CLINICAL CENTER

2202

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>1 1/2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban hospital</b>				d. STREET ADDRESS <b>4721 N. Chelsea Lane</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Kathryn</b> Middle <b>Smoot</b> Last <b>DuQuoin</b>				4. DATE OF DEATH Month <b>February</b> Day <b>19</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 14, 1884</b>		9. AGE (In years last birthday) <b>75</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hswf.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John M. Smoot</b>				14. MOTHER'S MAIDEN NAME <b>Brooks Minnie Brooks</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>yes-Unknown</b>			
17. INFORMANT <b>John S. DuQuoin (son)</b>				Address <b>same as above #2d</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>480X</b> DUE TO <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Influenza</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>1 week</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Feb 9</b> , 19 <b>60</b> , to <b>Feb 19</b> , 19 <b>60</b> ; that I last saw the deceased alive on <b>2/19/60</b> , 19 <b>60</b> , and that death occurred at <b>8:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6450 Wisconsin Ave, Bethesda, Md.</b> DATE SIGNED <b>2/19/60</b>							
ACTUAL SIGNATURE <b>D. Joseph Kenrick</b> M.D.				PHYSICIAN'S NAME (Type) <b>DR JOSEPH KENRICK</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>2/22/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>FEB 24 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kline</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 8

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portions. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1914

CERTIFICATE OF DEATH

2202

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

PLACE: \_\_\_\_\_

CAUSE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

2

MONTGOMERY MARYLAND											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2203 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>5073 SMITH COURT</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> d. STREET ADDRESS <b>5073 SMITH COURT</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>JOHN H. DYSON</b>					4. DATE OF DEATH <b>FEBRUARY 29 19 60</b>						
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>COL.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 4, 1907</b>		9. AGE (In years last birthday) <b>52</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUPT. GARAGE</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>AUTO</b>		11. BIRTHPLACE (State or foreign country) <b>D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>JOHN H. DYSON</b>					14. MOTHER'S MAIDEN NAME <b>SOPHIE MATTHEWS</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT <b>Katherine Dyson</b> Address <b>5000 River Road</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Frank J. Broschart</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <b>FEB. 29, 1960</b>			
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>3/3/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>		22d. LOCATION (City, town, or country) (State) <b>Suitland, Maryland</b>		
23. FUNERAL DIRECTOR <b>Charles E. Stewart</b>					ADDRESS <b>30 H Street, N.E.</b>			24a. REC'D BY REGISTRAR <b>MAR 3 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

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STATE OF NEW YORK  
JANUARY 1, 1960

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2204

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>✓</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>			c. LENGTH OF STAY IN 1b <b>5 days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Harould</b> Middle <b>Loyd</b> Last <b>ELDER</b>			4. DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-30-22</b>	9. AGE (In years last birthday) <b>37</b> yrs.	IF UNDER 1 YEAR Months <b>37</b> Days <b>3</b> Hours <b>46</b> Min. <b>3</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>	
13. FATHER'S NAME <b>Wyach ELDER</b>			14. MOTHER'S MAIDEN NAME <b>Ina FULLER</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II 418 36 3117</b>		INFORMANT Address <b>(Wife) Vera I. ELDER Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain Tumor (metastatic)</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma lung</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>1 month</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>19 February, 1960</b> , to <b>24 February, 1960</b> , that I last saw the deceased alive on <b>24 February, 1960</b> , and that death occurred at <b>8:50A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>W.H. Druckemiller</b> M.D. <b>U.S. Naval Hospital, Bethesda Md. 2-25-60</b> PHYSICIAN'S NAME (Type) <b>W.H. DRUCKEMILLER CAPT MC USN</b> <b>U.S. Naval Hospital, Bethesda Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/25/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dover Cemetery</b>	
				22d. LOCATION (City, town, or county) (State) <b>Dover Florida</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chamber</b>			24a. REC'D BY REGISTRAR <b>D.C. FEB 29 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME

AGE

RESIDENCE

CAUSE OF DEATH

DATE

(Initial)

U.S. Naval Hospital, Bethesda, Md.

SEX

AGE

RACE

DATE

TIME

U.S. Government

U.S. Navy

THE DEATH

WAS

418 30 (Wife) Verna I. Hinder

1911

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

DEATH

DEATH

DEATH

DEATH

U.S. Naval Hospital, Bethesda, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2205

## CERTIFICATE OF DEATH

Reg. Dist. No.

02143

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>26 Rockville</b> d. STREET ADDRESS <b>Norton &amp; South Glen Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Willis</b> Last <b>Embrey</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>20</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/17/17</b>
9. AGE (In years last birthday) <b>42</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>17</b> Hours <b>17</b> Min.	11. IF UNDER 24 HRS. Months <b>4</b> Days <b>17</b> Hours <b>17</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cab Dispatcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bethesda Cab Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Halto W. Embrey</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Emma May Simpson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-12-1955</b>	
17. INFORMANT <b>Slater</b>		Address <b>Mrs. Weaver-Purcellville, Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>491X</b> <b>Branchopneumonia, bilateral</b> DUE TO (b) <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c) <b>491X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe fatty degeneration liver</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 16</b> , 19 <b>60</b> , to <b>Feb 20</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Feb 19</b> , 19 <b>60</b> , and that death occurred at <b>5:45</b> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edward S. Witowski Jr.</b>		ADDRESS (Street, city or town, state) <b>Suite 400, 8218 Wisconsin Ave.</b> DATE SIGNED <b>2/20/60</b>	
PHYSICIAN'S NAME (Type) <b>Edward Witowski Jr.</b>		<b>Bethesda 14, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/23/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Round Hill, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>FEB 24 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

1313

CERTIFICATE OF DEATH

2202

INVESTIGATE STATE OF ALABAMA

ALABAMA DEPARTMENT OF HEALTH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The text is mirrored and appears to be bleed-through from the reverse side of the page.



## 2206 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA 57</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6307 TULSA LANE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELMER LINWOOD EVANS</b>		4. DATE OF DEATH Month Day Year <b>FEBRUARY 12 1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUCASOID</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 19, 1883</b>
9. AGE (In years last birthday) <b>76 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>1 23</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LIGHTING FIXTURES</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ROBERT G. EVANS</b>		14. MOTHER'S MAIDEN NAME <b>EMMA CATLIN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO.</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>578-09-5986</b> INFORMANT <b>MRS. EVANS</b> Address <b>6307 TULSA LANE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 DUE TO CONGESTIVE HEART FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b> <b>3 YEARS</b> <b>15 YEARS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INANITION; INFLUENZA-LIKE ILLNESS BEGAN FEB. 4, 1960</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>FEB. 4</b> , 1960, to <b>FEB. 12</b> , 1960, that I last saw the deceased alive on <b>FEB. 10</b> , 1960, and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Joseph D. Connor</b> M.D.		ADDRESS (Street, city or town, state) <b>7420 Old Georgetown Rd. Bethesda 14 Md.</b>	
PHYSICIAN'S NAME (Type) <b>JOSEPH D. CONNOR, M.D.</b>		DATE SIGNED <b>2/12/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/15/1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>		24a. RECEIVED BY REGISTRAR <b>FEB 15 1960</b> DATE	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
ALBANY, N. Y.

1930

ALBANY, N. Y.

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ALBANY, N. Y.

ALBANY, N. Y.

ALBANY, N. Y.

CERTIFICATE OF DEATH

Reg. Dist. No.

2207

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>54 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Hampshire</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Romney</b> d. STREET ADDRESS <b>No street address</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Viola</b> Middle <b>Virginia</b> Last <b>Feller</b>		4. DATE OF DEATH Month <b>February</b> Day <b>19</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 11, 1928</b>
9. AGE (In years lost birthday) <b>31</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Indian O. Sword</b>		14. MOTHER'S MAIDEN NAME <b>Ethel Kessel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>	
INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastro-Intestinal Hemorrhage</b> 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Lymphocytic Leukemia</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>5 Months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 27, 1959</b> to <b>February 19, 1960</b> , that I last saw the deceased alive on <b>February 19, 1960</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>2-19-60</b>			
ACTUAL SIGNATURE <b>Charles E. Mengel</b> M.D.		PHYSICIAN'S NAME (Type) <b>CHARLES E. MENGEL, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/22/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Luke's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>West Virginia Co.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b> ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>FEB 24 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG257 3-1-60 et

2208

## CERTIFICATE OF DEATH

Reg. Dist. No.

02146

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beallsville</b>		c. LENGTH OF STAY IN life		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beallsville,</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>AUGUSTA</b> Last <b>FISHER</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>7,</b> Year <b>19 60</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1870/ 1871</b>		9. AGE (In years last birthday) yrs. <b>88</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>John A. Fisher</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Alice Washington</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		INFORMANT <b>William R. Hood</b>		Address <b>Beallsville, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>446X Uremia</b> DUE TO (b) <b>Renal Arteriosclerosis</b> DUE TO (c) <b>Generalized Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>5 years</b> <b>10 years</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>4 Feb 1, 1960</b> , to <b>7 Feb 1, 1960</b> , that I last saw the deceased alive on <b>6 February 19 60</b> , and that death occurred at <b>2:45 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Barnesville, Md.</b>		DATE SIGNED <b>11 Feb 60</b>		ACTUAL SIGNATURE <b>John M. Smith</b>		M.D. <b>Bozonsville, Md.</b>		PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/11/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion,</b>		22d. LOCATION (City, town, or county) (State) <b>Barnesville, Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Sworden</b>		ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 24 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Clifton S. Hance</b>		24c. REGISTRAR'S SIGNATURE		24d. REGISTRAR'S SIGNATURE		24e. REGISTRAR'S SIGNATURE		24f. REGISTRAR'S SIGNATURE		24g. REGISTRAR'S SIGNATURE		24h. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 14 Film G257 3-1-60 et

2209

## CERTIFICATE OF DEATH

Reg. Dist. No.

02147

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>				c. LENGTH OF STAY IN 1b <b>17 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>IRENE</b> Middle <b>VIRGINIA</b> Last <b>FRAZIER</b>				4. DATE OF DEATH Month <b>2</b> Day <b>23</b> Year <b>1960</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 8, 1909</b>	
9. AGE (In years last birthday) <b>50</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>WILLIAM R. O'DANIEL</b>				14. MOTHER'S MAIDEN NAME <b>Unknown Nutie Goodwin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>HUSBAND</b>				Address <b>CHARLES WESLEY FRAZIER</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>175.0</b> DUE TO <b>Peritonitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Abdominal Carcinomatosis</b> DUE TO <b>2 years</b> (c) <b>Papillary Carcinoma of Ovary, Status post hysterectomy</b> DUE TO <b>2 years</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>58</b> , to <b>Feb 23</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Feb 23</b> , 19 <b>60</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John C. Murphy</b>		ADDRESS (Street, city or town, state) <b>1501 EYE ST NW Washington 6 DC</b>					
PHYSICIAN'S NAME (Type) <b>JOHN C. MURPHY,</b>		DATE SIGNED <b>2-24-60</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-24-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Montlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Wake County, North Car.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Humphrey Funeral Home</b>				24a. REC'D BY REGISTRAR <b>Bethesda, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kinn</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03135

CERTIFICATE OF DEATH

2202

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

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EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

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DATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
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FOR STATE  
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2118 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02148

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>WASHINGTON</b> <b>47X-3</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SEMINARY ROAD AND SUTTON PLACE</b>			d. STREET ADDRESS <b>7710 EASTERN AVE. N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>MOE</b> <b>FREIDIN</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>15</b> Year <b>1960</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/15/1902</b>		9. AGE (In years last birthday) <b>57</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HECKMAN PRODUCTS</b>		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>	
13. FATHER'S NAME <b>ABRAHAM FREIDIN</b>		14. MOTHER'S MAIDEN NAME <b>BERTHA UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Frances C. Freidin, 7710 Eastern Ave., NW Washington, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>sudden</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>2/15/60</b>	
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-16-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>KING DAVID MEM. GARDEN FALLS CHURCH. VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. DANZANSKY + SONS - 3501-14th St NW</b>		ADDRESS <b>FEB 18 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Huns</b>	



2210

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DETHESDA-</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		d. STREET ADDRESS <u>10106 HERFORD PLACE</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Margaret</u> Last <u>Gallagher</u>		4. DATE OF DEATH Month <u>2</u> Day <u>6</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/7/87</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Kohlman, Fred</u>	
14. MOTHER'S MAIDEN NAME <u>Annie Seier</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>none</u>		INFORMANT <u>Walter W. Gallagher</u> Address <u>10106 Herford Place</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension Heart Disease</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 6</u> , 19 <u>60</u> , to <u>Feb 6</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 6</u> , 19 <u>60</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. L. Tabb, M.D.</u>		ADDRESS (Street, city or town, state) <u>13000 GA. AVE. SILVER SPRING MARYLAND</u>	
PHYSICIAN'S NAME (Type) <u>S. L. TABB, M.D.</u>		DATE SIGNED <u>2-6-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-9-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's Cemetery Prince Georges, Ind.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Collins</u>		ADDRESS <u>3821-14th St. N.W. DC</u>	
24a. REC'D BY REGISTRAR <u>FEB 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.

VS A15 (4)  
15M 9/58

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

1  
MONTGOMERY STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02150

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>57 Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>1 mo.</u>		d. STREET ADDRESS <u>8613 Ewing Dr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fairland Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Julius Yertler</u>		4. DATE OF DEATH <u>Feb 25 1960</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-10-1880</u>	
9. AGE (In years last birthday) <u>80</u>		10. IF UNDER 1 YEAR Months Days 10 25 19 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Turner (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Montenegro Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Nursing Home Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary occlusion</u> (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u> <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2-25-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/26/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BNAI ISRAEL Cem</u>		22d. LOCATION (City, town, or country) (State) <u>Oxon Hill, MD</u>	
23. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u>		ADDRESS <u>4217-926 Ave</u>	
24a. REC'D BY REGISTRAR <u>DA FEB 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



## 2211 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <b>Michigan</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>111 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Grosse Pointe</b> 59X-3			
d. STREET ADDRESS <b>991 South Oxford Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Norman</b> Middle <b>Clyde</b> Last <b>Geyer</b>				4. DATE OF DEATH Month <b>February</b> Day <b>28</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 11, 1892</b>	
9. AGE (In years last birthday) <b>67</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manufacturer</b>		11. BIRTHPLACE (State or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William F. Geyer</b>				14. MOTHER'S MAIDEN NAME <b>Margaret A. Blakely</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>352-07-1716</b>			
17. INFORMANT <b>The Medical Record</b>				Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant carcinoid syndrome</b> 229X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Broncho-pneumonia</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>November 9, 1959</b> to <b>February 28, 1960</b> , that I last saw the deceased alive on <b>February 28, 1960</b> , and that death occurred at <b>4:00 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Victor W. Sidel</b>				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>2/29/60</b>			
PHYSICIAN'S NAME (Type) <b>Victor W. Sidel, M.D.</b>				M.D. <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>2/29/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Forrestlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Detroit, Michigan</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>				ADDRESS <b>2901 14th St. N.W.</b> <b>Washington 9, D.C.</b>			
24a. REC'D BY REGISTRAR <b>MAR 1 '60</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3211

INVESTIGATION OF DEATH

Michigan

Michigan

James T. Jones

III. Case

Michigan

1911 South Central Road

The Clinical Center, Bethesda, Md.

February

1911

1911

1911

August 11, 1911

1911

1911

1911

U.S.A.

Michigan

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The Clinical Center, Bethesda, Md.

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Item 18 Film 258  
3-10-60 ams

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02152

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolsville</u>	
c. LENGTH OF STAY IN TB <u>DOA</u>		d. STREET ADDRESS <u>SUBURBAN</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Peggy</u> Middle <u>JANET</u> Last <u>GIBSON</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 20 1960</u>
9. AGE (In years last birthday) <u>1</u> - yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>29</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethesda Md</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>RONALD GIBSON</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Keen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Matthew Sane as item 2</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>501X</u> <u>Laryngo-tracheal bronchitis, acute slight</u> DUE TO <u>Pulmonary edema, marked</u> Conditions, if any, which gave rise to immediate cause (b) <u>Focal hemorrhages, pulmonary parenchymal &amp; plural</u> (c) <u>Mesenteric lymphadenitis</u> DUE TO <u>Visceral Congestion, marked</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden death</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/22/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		22d. LOCATION (City, town, or county) (State) <u>Beallville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hillen</u> ADDRESS <u>Beallville Md</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 24 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2051162XU5







02153

## CERTIFICATE OF DEATH

Reg. Dist. No.

MEDICAL CERTIFICATION	1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>mont.</u>				
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Footsville</u>				
	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>1</u>				
	3. NAME OF DECEASED (Type or print) First <u>Carter</u> Middle <u>S.</u> Last <u>GILLIS</u>		4. DATE OF DEATH Month <u>February</u> Day <u>28</u> Year <u>1960</u>				
	5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8 - 1907</u>	9. AGE (In years last birthday) <u>52</u> yrs.	10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS.
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cheng-yuan</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Episcopal Church N. H.</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY?
	13. FATHER'S NAME <u>William Weir Gillis</u>		14. MOTHER'S MAIDEN NAME <u>Carter, Isabelle</u>				
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>420.1</u>		INFORMANT <u>Edith Gillis - Footsville, Md.</u> Address		
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary insufficiency</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>5 years</u> <u>8 years</u>				
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hypertension</u>					
20c. TIME OF INJURY Hour a. m. <u>19</u> Month <u>March</u> Day <u>28</u> Year <u>1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Washington, DC</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1953</u> to <u>Feb 28</u> , 1960, that I last saw the deceased alive on <u>28 Feb</u> , 1960, and that death occurred at <u>7:10 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Washington, DC</u>		DATE SIGNED <u>2/28/60</u>			
ACTUAL SIGNATURE <u>John Fawcett</u> M.D. <u>Dawsonville</u>		PHYSICIAN'S NAME (Type) <u>John Fawcett</u>		P.O. Box <u>28</u> , <u>MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/2/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hillen</u>		ADDRESS <u>Barnesville, Md</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Hanna</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/5B

CERTIFICATE OF DEATH

1913

*[Faint, illegible text, likely bleed-through from the reverse side of the document]*

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
2214 CERTIFICATE OF DEATH

02154

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>16 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Congressional Manor Sanitarium</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <b>1801 E. Montgomery Ave</b>							
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>Aleta</b> Last <b>Graham</b>				4. DATE OF DEATH Month <b>Februaury</b> Day <b>9</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 11, 1872</b>	
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>US</b>							
13. FATHER'S NAME <b>Andrew J. Ferguson</b>				14. MOTHER'S MAIDEN NAME <b>Famantha Whims</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. James H. Taylor-daughter-same 2d</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332x Cerebral Embolism</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized ARTERIO SCLEROSIS</b> DUE TO (c) <b>AGE</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 HR</b> <b>Adm. Yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 1950</b> to <b>Feb 1960</b> , that (I) (we) last saw the deceased alive on <b>Feb 1960</b> , and that death occurred <b>12 noon</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Leo I. Donovan</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/10/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Leo I. Donovan, M.D.</b>		22d. ADDRESS <b>5066 Georgetown Road Bethesda Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/13/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Prince George Co. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 11 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>C. L. S. Kline</b>			

BP

175-202500

2215  
CERTIFICATE OF DEATH

Reg. Dist. No.

02155

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RDI, Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>56 Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Bridford Rest Home, RDI, Silver Spring</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Sarah H. ANN GRAY</i>		4. DATE OF DEATH Month <i>2</i> Day <i>12</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1872</i>
9. AGE (In years last birthday) <i>88</i> yrs.		10. IF UNDER 1 YEAR: Months <i>88</i> Days <i>88</i> Hours <i>88</i> Min. <i>88</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Daniel Lewis, Nephew</i>		Address <i>806 Colby Ave. Takoma Park, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> 433.0 DUE TO <i>Stokes-Adams Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO (c) <i>Arteriosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>Several years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Oct 1, 1958</i> to <i>Feb 12, 1960</i> , that I last saw the deceased alive on <i>Feb 11, 1960</i> , and that death occurred at <i>3:50 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Clive E. Jackson</i>		ADDRESS (Street, city or town, state) <i>RDI, Grothensburg, Md.</i> DATE SIGNED <i>2-12-60</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (City)	22b. DATE THEREOF <i>2/16/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Ash Memorial.</i>	22d. LOCATION (City, town, or county) (State) <i>Sandy Spring, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Rupert L. Lunden</i>		ADDRESS <i>Rockville, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>FEB 15 '60</i>
		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One of Two

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>10/15/1925</i></p>	
<p>5. PLACE OF BIRTH <i>Baltimore, Maryland</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>		<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>05/10/1948</i></p>	
<p>9. PLACE OF DEATH <i>Home</i></p>		<p>10. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>11. MANNER OF DEATH <i>Natural</i></p>		<p>12. DATE OF DEATH <i>11/10/1970</i></p>	
<p>13. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>14. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>15. SIGNATURE OF PHYSICIAN <i>John Doe</i></p>		<p>16. SIGNATURE OF REGISTRAR <i>John Doe</i></p>	

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his last illness.

2. The cause of death should be stated in as much detail as possible, and should be based on the findings of the physician or other qualified person.

3. The manner of death should be stated as natural, accidental, or homicidal.

4. The date of death should be stated in full, including the day, month, and year.

5. The signature of the deceased, if known, should be written in the space provided.

6. The signature of the witness, if known, should be written in the space provided.

7. The signature of the physician, if known, should be written in the space provided.

8. The signature of the registrar, if known, should be written in the space provided.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2216

## CERTIFICATE OF DEATH

Reg. Dist. No.

02156

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd's RFD</u>		c. LENGTH OF STAY IN lb <u>10 yr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>RFD #1</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN THOMAS GRIFFIN</u>		4. DATE OF DEATH <u>FEBRUARY 28 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/25/79</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Iva Griffin</u>	
14. MOTHER'S MAIDEN NAME <u>Anne Byram</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>Unknown</u>		INFORMANT <u>Morgan Lee Griffin Rt. #3 Gaithersburg,</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>UREMIA</u> DUE TO (c) <u>ARTERIOSCLEROTIC KIDNEY DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>2 MONTHS</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DECUBITUS ULCERS</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>23 Jan 1959</u> to <u>28 Feb 1960</u> , that I last saw the deceased alive on <u>28 Feb 1960</u> , and that death occurred at <u>8:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Fawcett MD.</u> M.D.		ADDRESS (Street, city or town, state) <u>PO. BOYD MARYLAND</u> DATE SIGNED <u>2/28/60</u>	
PHYSICIAN'S NAME (Type) <u>JOHN. FAWCETT</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-2-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Walker Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Madison, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 1 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS  
COUNTY OF DALLAS

BEFORE ME, the undersigned authority, on this day personally appeared \_\_\_\_\_

known to me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

Notary Public in and for the State of Texas

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

WITNESSES my hand and seal of office this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

Notary Public in and for the State of Texas

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

WITNESSES my hand and seal of office this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

Notary Public in and for the State of Texas

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

WITNESSES my hand and seal of office this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

Notary Public in and for the State of Texas

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

WITNESSES my hand and seal of office this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

Notary Public in and for the State of Texas

My commission expires this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

WITNESSES my hand and seal of office this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

## CERTIFICATE OF DEATH

Reg. Dist. No.

02157

2139

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN 1b <b>unknown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Clarence</b> Last <b>Griffin</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>4</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/19/1885</b>
9. AGE (In years lost birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Supt. Paints &amp; Finishing</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Senate Bldg.</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George M. Griffin</b>		14. MOTHER'S MAIDEN NAME <b>Catherine ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mary J. Griffin</b>		Address <b>Takoma Pk. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442x</b> DUE TO <b>Had a fall exposure to cold</b> (Part II) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic cardiac renal disease - years</b> DUE TO <b>Valvular heart disease since age 11 yrs</b> (c) <b>Valvular heart disease since age 11 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter no. of injury in Part I or Part II of item 18.) <b>Fell off back porch</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>1 26 60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1959</b> to <b>Feb 4</b> , 19 <b>60</b> that I last saw the deceased alive on <b>Feb. 3</b> , 19 <b>60</b> , and that death occurred at <b>12:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1831 Varnum St NE.</b> DATE SIGNED <b>Leland S. Madden</b>			
ACTUAL SIGNATURE <b>Leland S. Madden</b>		M.D. <b>1831 Varnum St NE.</b>	
PHYSICIAN'S NAME (Type) <b>Leland S. Madden</b>		<b>Washington 18 DC.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/6/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Liffman Co</b>		ADDRESS <b>2901-14th NW</b>	
24a. REC'D BY REGISTRAR <b>FEB 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NS151

CERTIFICATE OF DEATH

2133

Maryland

Montgomery

Washington

Unknown

Laurel Park

Washington District

5011 E. on 10th St. N.W.

Orville

Clarence

William

Walter

Maria

1910-1962

75

Laurel Park, Washington, D. C.

Washington, D. C.

Washington

George F. Smith

Mary F. Smith, 5011 E. on 10th St. N.W.

None

None

1910-1962

Washington, D. C.

Laurel Park, Washington, D. C.

1910-1962

## 2217 CERTIFICATE OF DEATH

Reg. Dist. No.

02158

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>1436 Whittier Place, N.W.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Toby</b> Middle <b>Pauline</b> Last <b>Gutwerk</b>		4. DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>1960</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 10, 1940</b>		9. AGE (In years lost birthday) <b>19</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(Student) None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Nathan Gutwerk</b>				14. MOTHER'S MAIDEN NAME <b>Sabina Naiman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage into the Mid-Brain</b> 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Myelogenous Leukemia</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>  <b>Months</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 27, 1960</b> , to <b>February 24, 1960</b> , that I last saw the deceased alive on <b>February 24, 1960</b> , and that death occurred at <b>6:40 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>2-24-60</b>							
ACTUAL SIGNATURE <b>Richard C. Mechanic</b> M.D.				PHYSICIAN'S NAME (Type) <b>RICHARD C. MECHANIC, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>2-25-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>KING DAVID MEM. GARDEN FALLS CHURCH</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. DANZANSKY + SONS - 3501 - 14th ST. N.W.</b>				24a. RECEIVED BY REGISTRAR <b>FEB 26 60</b>		24b. REGISTRAR'S SIGNATURE <b>John E. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

02158

2212

Ministry of Health

Washington

28 days

Belgrade

10.11.1943

The Central Institute of Health

Belgrade

Belgrade

1943

10.11.1943

10.11.1943

10.11.1943

Ministry of Health

Belgrade

Belgrade

Belgrade

Belgrade

The Central Institute of Health

Belgrade

Belgrade

10.11.1943

10.11.1943

The Central Institute of Health  
Belgrade

Belgrade



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2140

## CERTIFICATE OF DEATH

Reg. Dist. No.

02159

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PG</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u> 16x2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hosp.</u>				d. STREET ADDRESS <u>Crane's Trailer Court</u>			
3. NAME OF DECEASED (Type or print) <u>Stewart</u> First Middle Last <u>G. HALLIDAY</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 28, 1904</u> 55 yrs.	9. AGE (In years last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Arthur Halliday</u>				14. MOTHER'S MAIDEN NAME <u>Klein</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or date of service)		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH. <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 26, 1960</u> to <u>Feb 12, 1960</u> , that I last saw the deceased alive on <u>Feb 12, 1960</u> , and that death occurred at <u>10:48</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Boris Rabin</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>1019 University Boulevard Feb 14/60</u>			
PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u>				<u>Silver Spring Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 17, 1960</u>		<u>FT. LINCOLN CEMETERY</u>		<u>Bladensburg Rd. Pk. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walker</u>				ADDRESS <u>254 Carroll St. NW.</u>		24a. REC'D BY REGISTRAR <u>FEB 17 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

IN A  
BOYD

Name of deceased		Sex		Age		Date of death	
Place of death		Cause of death		Manner of death		Occupation	
Residence		Hospital		Physician		Coroner	
Burial place		Burial date		Burial time		Burial place	
Signature of physician		Signature of coroner		Signature of registrar		Signature of witness	
Date of certificate		Time of certificate		Place of certificate		Signature of registrar	

## 2218 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>5 da 14 hr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>47X-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				d. STREET ADDRESS <b>3804 Veazey Street N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>L</b> Last <b>Harding</b>				4. DATE OF DEATH Month <b>February</b> Day <b>1</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 9, 1874</b>	
9. AGE (In years lost day) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Leesburg, Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>							
13. FATHER'S NAME <b>Wallace</b>				14. MOTHER'S MAIDEN NAME <b>Adelaide Kelly</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>none</b>		INFORMANT <b>Son</b> <b>Sam e s above</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Failure</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Hypertensive Cardio-Vascular Disease</b> DUE TO (c) <b>17 yrs. +</b>							INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June</b> , 19 <b>43</b> , to <b>Feb. 1</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan. 30</b> , 19 <b>60</b> , and that death occurred at <b>8:15</b> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Karl Dortzbach</b>				ADDRESS (Street, city or town, state) <b>Washington Clinic</b> DATE SIGNED <b>2/1/60</b>			
PHYSICIAN'S NAME (Type) <b>Karl Dortzbach, M.D.</b>				<b>D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>2/3/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Leesburg, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>				24a. REC'D BY REGISTRAR <b>FEB 2 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove covering papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2214

State of Virginia

County

City

Year

Month

Day

Hour

Minute

Second

Time

Place

Age

Sex

Color

Height

Weight

Build

Complexion

Scars

Education

Occupation

Marital Status

Religion

Political Party

Previous Convictions

Signature

Witness

Notary Public

Commission Expires

## 2219 CERTIFICATE OF DEATH

02161

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown-Rural</b>				c. LENGTH OF STAY IN 1b <b>2 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Marylander Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>William</b> Last <b>Harman</b>				4. DATE OF DEATH Month <b>February</b> Day <b>16</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 29, 1877</b>		9. AGE (In years last birthday) yrs. <b>82</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>17</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Caretaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John E. Harman</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Best</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		INFORMANT Address <b>Lester Harman-son-City 13, Rockville Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Acute congestive heart failure</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>15 years</b> <b>25 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May, 1959</b> , to <b>16 Feb 1960</b> that I last saw the deceased alive on <b>16 Feb 1960</b> , and that death occurred at <b>12:00 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. G. Hall</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>615 W. Montg. Ave. Rockville, Md 2/16/60</b>			
PHYSICIAN'S NAME (Type) <b>W. G. Hall</b>				615 W. Montg. Ave. Rockville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/19/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 23 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

81 400 67 89

10



CERTIFICATE OF DEATH

Reg. Dist. No. 02162

2120

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Springs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Springs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8922-GEORGIA AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>LAWRENCE</b> Last <b>HARRINGTON</b>		4. DATE OF DEATH Month <b>FEB</b> Day <b>18</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WH</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NO 23, 1877</b>
9. AGE (In years lost birthday) <b>82 yrs.</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>18</b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>VA</b>	
11. BIRTHPLACE (State or foreign country) <b>VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>MONTGOMERY</b>	
13. FATHER'S NAME <b>WM CHICHESTER</b>		14. MOTHER'S MAIDEN NAME <b>MARY ELIZABETH FORD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>JOHN F. HARRINGTON - 8922 GEORGIA AVE SPRING</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>155.1</b> DUE TO <b>Cardiac failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>carcinomatous</b> DUE TO <b>Primary CA. gall bladder</b> (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 month</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 1960</b> to <b>Feb 18, 1960</b> that I last saw the deceased alive on <b>Feb 18, 1960</b> and that death occurred at <b>8:10 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John F. Harrington</b> M.D.		ADDRESS (Street, city or town, state) <b>3810-12 NE</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>John F. HARRINGTON</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2/22/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>PRESBYTERIAN CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>ALEXANDER VA</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anthony Haddon - 3831 - GA. AVE</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 24 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>

CERTIFICATE OF DEATH

3150

05185

Blank certificate form with horizontal lines for text entry.

ORIGINAL FILED IN

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2141

CERTIFICATE OF DEATH

02163

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>District of Columbia</i> b. COUNTY <i>47X-3</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN lb <i>40 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium Hosp.</i>				d. STREET ADDRESS <i>2853 Ontario Rd N.W.</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <i>Anna Margaret Harris</i>				4. DATE OF DEATH Month Day Year <i>Feb. 1 1960</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9-27-79</i>	
9. AGE (In years lost birthday) <i>80</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>John A. Boote</i>				14. MOTHER'S MAIDEN NAME <i>Mary Elizabeth Mason</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>W.S. Hosp. Records</i>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Congestive Heart Failure</i> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <i>one week</i> <i>two months</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Feb 1</i> , 19 <i>53</i> , to <i>Feb 1</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Feb 1</i> , 19 <i>60</i> , and that death occurred at <i>12:25 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Robert A. Hare</i>				ADDRESS (Street, city or town, state) <i>Takoma Park, Md.</i>			
PHYSICIAN'S NAME (Type) <i>Robert A. Hare M.D.</i>				DATE SIGNED <i>2/1/60</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>2/4/60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cem. Ft. Myer, Va.</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>S.H. Jones Co</i>				24a. REC'D BY REGISTRAR <i>2901-1447 N.W.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kraus</i>	
ADDRESS <i>Washington 9, D.C.</i>				DATE <i>FEB 2 '60</i>			



## 2220 CERTIFICATE OF DEATH

Reg. Dist. No.

02164

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Chas. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14571 Coleville Rd.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Chton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARLEA SANITARIUM</u>		d. STREET ADDRESS <u>08X-2</u>	
3. NAME OF DECEASED First <u>SADYE</u> Middle <u>MADDOX</u> Last <u>HAYDEN</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2-1886</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min. <u>73</u>	IF UNDER 24 HRS. Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min. <u>73</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (State or foreign country) <u>CHARLES CO. MD</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>JOHN W. MADDOX</u>	
14. MOTHER'S MAIDEN NAME <u>ELLA SMITH</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>L. Edwin Hayden</u> Address <u>9808 Parkwood Dr. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Beach 26 miles accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO <u>years</u> (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-15-59</u> to <u>2-15-60</u> , that I last saw the deceased alive on <u>2-15-60</u> , 19 <u>60</u> , and that death occurred at <u>5:10</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. Hayden</u> M.D.		ADDRESS (Street, city or town, state) <u>1819 Semmes Rd</u> DATE SIGNED <u>2-15-60</u>	
PHYSICIAN'S NAME (Type) <u>John W. Hayden</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-18-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Ignace's Cem.</u>	22d. LOCATION (city, town, or county) (State) <u>Bel Chton Chas. Co. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u> ADDRESS <u>1661 Good Hope Rd. Wash. 20002</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 17 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2179

02165

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>304 N. Adams St. Apt. 160</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sherry Ann Henderson</u>				4. DATE OF DEATH <u>Feb 21 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-2-1957</u>	
9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>21</u>		IF UNDER 24 HRS. Hours <u>2</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Howard Henderson</u>				14. MOTHER'S MAIDEN NAME <u>Mattie Ruth Reiney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Howard Henderson (father)</u> Address <u>Stim 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Epileptic Seizure</u> <u>351X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral Palsy</u> (c) <u>—</u> DUE TO Cause lost. (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>Same/dead in bed</u> life							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2-21-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Bur-Transit</u>		<u>2/22/60</u>		<u>Evergreen</u>		<u>Macon, Georgia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u> ADDRESS <u>1331 E. Montg. Ave. Rockville, Md.</u>				24a. REC'D BY REGISTRAR <u>FEB 24 1960</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

2

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF CEMETERY		20. SIGNATURE OF INTERMENT		21. SIGNATURE OF RECORDS	
22. SIGNATURE OF VITALS		23. SIGNATURE OF DEATH		24. SIGNATURE OF CERTIFICATE	
25. SIGNATURE OF DEATH		26. SIGNATURE OF DEATH		27. SIGNATURE OF DEATH	
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IF CONSULTED

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. OCCUPATION  
5. MARITAL STATUS  
6. PLACE OF BIRTH  
7. DATE OF DEATH  
8. TIME OF DEATH  
9. PLACE OF DEATH  
10. CAUSE OF DEATH  
11. MANNER OF DEATH  
12. SIGNATURE OF EXAMINER  
13. SIGNATURE OF ATTENDING PHYSICIAN  
14. SIGNATURE OF CORONER  
15. SIGNATURE OF JURY  
16. SIGNATURE OF WITNESSES  
17. SIGNATURE OF FUNERAL HOME  
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102. SIGNATURE OF DEATH

## CERTIFICATE OF DEATH

Reg. Dist. No. 02166

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDNOR</u>		c. LENGTH OF STAY IN 1b <u>1 MON-3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Belmont Farm Nursing Home</u>		d. STREET ADDRESS <u>4118-29<sup>th</sup> Street</u>	
3. NAME OF DECEASED (Type or print) <u>Otto. Theodore Herberger</u>		4. DATE OF DEATH <u>2 13 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-23-1860</u>
9. AGE (In years last birthday) <u>99</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Elizabeth G. Laughton</u>		18. ADDRESS (Street, city or town, state) <u>#204-Rainier Ave. Mt. Rainier, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>600.0</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic pyelonephritis</u> (c) <u>Parkinsonism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 Wk.</u> <u>Yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinsonism</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/10, 1960</u> to <u>2/13, 1960</u> , that I last saw the deceased alive on <u>2/7, 1960</u> , and that death occurred at <u>5:01 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. H. Herger</u>		ADDRESS (Street, city or town, state) <u>Jandy Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>C. H. Herger</u>		DATE SIGNED <u>2/13/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/16/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>		ADDRESS <u>Mt. Rainier, Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 17 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**ACKNOWLEDGMENTS**





# CERTIFICATE OF DEATH

State of Virginia

County of

City of

Age

Residence

House No. 1, Box 10

The Clinical Center, Bethesda, Md.

Married

Single

Married

October 1, 1910

x

White

Female

USA

North Carolina

Married

Residence

Ada Larson

John H. Horney

The Federal Board

The Clinical Center, Bethesda, Md.

Married

No

2 years

Usual

2 years

Duration of the Case

January 2, 1910

February 10, 1910

1-10-10

The Clinical Center

National Institute of Health

Bethesda, Md., Maryland

Signature of Physician

Signature of Registrar



2170

## CERTIFICATE OF DEATH

02168

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. LENGTH OF STAY IN 1b <b>#3 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Sanitarium</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William John</b> Middle <b>Hill</b> Last		4. DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar 4, 1879</b>
9. AGE (In years and birth day) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Printing Pressman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bureau of Printing and Engraving</b>	
11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Hill</b>		14. MOTHER'S MAIDEN NAME <b>Mary Anne Drew</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Ethel G. Hill, 1917-38th., St., N.W., Wash. D.C.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertension</b> 340.3 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Infection, location undetermined, possible meningitis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 26 1960</b> to <b>February 2 1960</b> , that I last saw the deceased alive on <b>February 2 1960</b> , and that death occurred at <b>6:30 p.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert T. Thibadeau</b>		ADDRESS (Street, city or town, state) <b>10609 Concord Street</b>	
PHYSICIAN'S NAME (Type) <b>Robert T. Thibadeau, M.D.</b>		DATE SIGNED <b>Feb 2, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/5/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Nat. Mem. Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Falls Church, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Cherry Chase Funeral Home Wash. D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 8 '60</b>	
ADDRESS <b>5703 Wisconsin</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

02169

2223

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>4 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Fannie</b> Middle <b>M. Hilton</b> Last 4. DATE OF DEATH Month <b>February</b> Day <b>14</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1870</b>
9. AGE (In years lost birthday) yrs. <b>89</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John F. XXXXX Bohrer</b>		14. MOTHER'S MAIDEN NAME <b>Louisa R. Duvall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>William Griffin Maple View Drive</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Hypertensive Cerebral Vascular Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 10</b> , 19 <b>60</b> , to <b>FEB 14</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Feb 14</b> , 19 <b>60</b> , and that death occurred at <b>10:55 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>P. P. Andrews M.D. 4701 Fessenden ST NW 2-14-60</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>P. P. ANDREWS Washington D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 17, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Damascus Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Damascus, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>		ADDRESS <b>Laytonsville, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 18 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

CERTIFICATE OF DEATH

1902

10310

Age	10 years
Sex	Male
Color	White
Married	Single
Occupation	Student
Place of Birth	Georgia
Usual Residence	Savannah, Ga.
Date of Death	October 2, 1902
Time of Death	10:00 AM
Place of Death	Home
Cause of Death	Scarlet Fever
Immediate Cause	Scarlet Fever
Underlying Cause	Scarlet Fever
Duration of Illness	10 days
Signature of Physician	[Signature]
Signature of Registrar	[Signature]
Signature of Coroner	[Signature]

## 2224 CERTIFICATE OF DEATH

Reg. Dist. No.

02170

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDNOR M.D.</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BEIMONT NURSING Home</u>				d. STREET ADDRESS <u>610 BONIFANT ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HOLLOWAY JOHN J. HOLLOWAY</u>				4. DATE OF DEATH Month <u>2</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/9/68</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN, (retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Singer Sewing Machine Co.</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>519-20-1745A</u>			
				INFORMANT <u>Claire Jay Belmont</u> Address <u>Belmont</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>600.0</u> DUE TO <u>Chronic Pyelonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Pyelonephritis</u> (c) <u>6 mo</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10/6</u> , 19 <u>59</u> , to <u>2/8</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/7</u> , 19 <u>60</u> , and that death occurred at <u>4:00 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C.H. Logan</u>				ADDRESS (Street, city or town, state) <u>Sandy Spring, Md.</u> DATE SIGNED <u>2/8/60</u>			
PHYSICIAN'S NAME (Type) <u>C.H. Logan</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/11/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>FEB 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

1

1

1

1

Washington

Edwin M.D.

Belmont National Home

Washington

July 1, 1904

Dear Sir

I have the honor to acknowledge the receipt of your letter of the 28th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Your obedient servant,

Wm. H. Brown

Director

Belmont National Home

Washington

Very truly yours,

Wm. H. Brown

Director

Belmont National Home

Washington

Enclosed please find

copy of report

of the

Commissioner

of the

Washington

Edwin M.D.

Belmont National Home

Washington

July 1, 1904

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Washington

Enclosed please find

copy of report

of the

Commissioner

of the



may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 2171  
 CERTIFICATE OF DEATH

02171

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENSINGTON GARDENS SANITARIUM</b>				d. STREET ADDRESS <b>1405 G St. N.W.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>HATTIE MARY HOOVER</b>				4. DATE OF DEATH Month Day Year <b>FEB 7 1960</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/13/71</b>	
9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William Osborne</b>				14. MOTHER'S MAIDEN NAME <b>Ella Flynn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>			
17. INFORMANT <b>James O. Hoover</b>				Address <b>5705 Maiden Lane Bethesda, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized ARTERIOSCLEROSIS</b> DUE TO (c) <b>AGE</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 days</b> INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1958</b> to <b>Jan 6 1960</b> , that (I) (we) lost saw the deceased alive on <b>Jan 4 1960</b> , and that death occurred at <b>12:59 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Leo I Donovan M.D.</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>LEO I DONOVAN M.D.</b>				22d. ADDRESS <b>8016 GEORGETOWN RD BETHESDA 14 MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>				23b. DATE THEREOF <b>2/9/60</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>				25a. REC'D BY REGISTRAR <b>DA FEB 9 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>							

MINISTRE OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Date of registration		12. Place of registration	
13. Name of informant		14. Relationship to deceased		15. Signature of informant	
16. Name of informant		17. Relationship to deceased		18. Signature of informant	
19. Name of informant		20. Relationship to deceased		21. Signature of informant	
22. Name of informant		23. Relationship to deceased		24. Signature of informant	
25. Name of informant		26. Relationship to deceased		27. Signature of informant	
28. Name of informant		29. Relationship to deceased		30. Signature of informant	
31. Name of informant		32. Relationship to deceased		33. Signature of informant	
34. Name of informant		35. Relationship to deceased		36. Signature of informant	
37. Name of informant		38. Relationship to deceased		39. Signature of informant	
40. Name of informant		41. Relationship to deceased		42. Signature of informant	
43. Name of informant		44. Relationship to deceased		45. Signature of informant	
46. Name of informant		47. Relationship to deceased		48. Signature of informant	
49. Name of informant		50. Relationship to deceased		51. Signature of informant	
52. Name of informant		53. Relationship to deceased		54. Signature of informant	
55. Name of informant		56. Relationship to deceased		57. Signature of informant	
58. Name of informant		59. Relationship to deceased		60. Signature of informant	
61. Name of informant		62. Relationship to deceased		63. Signature of informant	
64. Name of informant		65. Relationship to deceased		66. Signature of informant	
67. Name of informant		68. Relationship to deceased		69. Signature of informant	
70. Name of informant		71. Relationship to deceased		72. Signature of informant	
73. Name of informant		74. Relationship to deceased		75. Signature of informant	
76. Name of informant		77. Relationship to deceased		78. Signature of informant	
79. Name of informant		80. Relationship to deceased		81. Signature of informant	
82. Name of informant		83. Relationship to deceased		84. Signature of informant	
85. Name of informant		86. Relationship to deceased		87. Signature of informant	
88. Name of informant		89. Relationship to deceased		90. Signature of informant	
91. Name of informant		92. Relationship to deceased		93. Signature of informant	
94. Name of informant		95. Relationship to deceased		96. Signature of informant	
97. Name of informant		98. Relationship to deceased		99. Signature of informant	
100. Name of informant		101. Relationship to deceased		102. Signature of informant	

2225

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>1 da</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Horst</u> Last <u>Horst</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>1</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 4, 1879</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Joseph</u>				14. MOTHER'S MAIDEN NAME <u>Sara Linesay</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>- - - - -</u>				16. SOCIAL SECURITY NO. <u>None</u>			
INFORMANT Address <u>George S. Smith-Item #2-Son-in-law</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive heart failure, acute stroke of left side, rupture left cerebral myocardial infarction (cor. occlusion)</u> DUE TO (b) <u>5 days</u> DUE TO (c) <u>1 week</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2/1</u> , 19 <u>60</u> , to <u>2/1</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-1</u> , 19 <u>60</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gilbert B. Rude</u> M.D.				ADDRESS (Street, city or town, state) <u>3900 military rd N.W. D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Gilbert B. Rude</u>				DATE SIGNED <u>2/1/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-5-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2000

Mr. Jones

Thursdays

London

John Liberty

None

George & John Liberty 22-10-1911

Serial 1-2-5-00

Robert A. Jones, deceased, buried

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG256 2-19-60 et

## CERTIFICATE OF DEATH

02173

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ashton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ashton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>--</b>		d. STREET ADDRESS <b>"Mount Airy"</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FLOYD</b> Middle <b>E.</b> Last <b>Huntley</b>		4. DATE OF DEATH Month <b>2</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 10, 1881</b>
9. AGE (In years lost birthday) <b>78 7/8</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Publisher</b>	
11. BIRTHPLACE (State or foreign country) <b>Cherry Creek N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Reed Huntley</b>		14. MOTHER'S MAIDEN NAME <b>Fidelia Frost</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
INFORMANT <b>Mrytle Huntley</b>		Address <b>Ashton Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of colon with metastases</b> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>56</b> to <b>2/13</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>2/13</b> , 19 <b>60</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>3/13/60</b>			
ACTUAL SIGNATURE <b>C. H. Ligon</b>		M.D. <b>Sandy Spring, Md.</b>	
PHYSICIAN'S NAME (Type) <b>C. H. Ligon</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Shipped</b>	22b. DATE THEREOF <b>2/15/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Forrest Lawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Buffalo, N.Y.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOSEPH GAWLER'S SONS, INC.</b>		24a. REC'D BY REGISTRAR <b>FEB 16 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

2222

Montgomery

London

London

FLOID

E.

Oct. 10, 1901

Male

Cherry Creek N.Y.

Notice

William Reed Hunter

Idalia Trout

none

no

Myrtle Hunter

London N.Y.

*Handwritten signature and notes*

*Handwritten signature and notes*

*Handwritten signature and notes*



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02174

Reg. Dist. No. 215

FOR STATE  
HEALTH DEPT.

051

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> o. STATE <u>Indiana</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN lb <u>13 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion</u> <u>52x-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>			d. STREET ADDRESS <u>1815 Miller Ave.</u> <u>Fl5 Fairfield Trailer Ct.</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lionel Vernon HUSTON</u>			4. DATE OF DEATH Month Day Year <u>February 18 1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-34</u>		9. AGE (In years last birthday) <u>25</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>John David Huston</u>			14. MOTHER'S MAIDEN NAME <u>Helen Mae Adams</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes 1952 to DOD</u>		16. SOCIAL SECURITY NO. <u>312-32-6800</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>823X</u> DUE TO Conditions, if any, which gave rise to the immediate cause (a), stating the underlying cause last. (b) <u>Fracture of skull</u> DUE TO (c) <u>Multiple injuries extreme</u> INTERVAL BETWEEN ONSET AND DEATH <u>27 hours</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in pvt. auto which skidded off road and struck tree</u>			
20c. TIME OF INJURY Month, Day, Year <u>1:40 p.m. 2/17 1960</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 222 near Bainbridge Md Lancaster Pa.</u>	
20f. (City or town) (County) (State) <u>Marion Indiana</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Shipment</u>		22b. DATE THEREOF <u>2-19-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Garden of Memories</u>	
				22d. LOCATION (City, town, or county) (State) <u>Marion Indiana</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers by Lion</u>		ADDRESS <u>WashDC</u>		24a. REC'D BY REGISTRAR <u>FEB 23 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	
VS. A15ME SM 2/57 <u>W.W. Chambers Funeral Home, 1400 Chapin St. NW,</u>					

TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

✓

2

88

2



## CERTIFICATE OF DEATH

Reg. Dist. No.

02175

2228

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hosp.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksville</b> <b>13X-2</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <b>Hall Shop Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle Last <b>Iager</b>		4. DATE OF DEATH Month <b>February</b> Day <b>10</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/12/1880</b>
9. AGE (In years lost birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Iglehart</b>		14. MOTHER'S MAIDEN NAME <b>Mary Harding</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hospital Records,</b>		Address <b>Olney, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive cerebral hemorrhage</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 331X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute myocardial failure -- 10 days</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 1</b> , 19 <b>60</b> , to <b>Feb. 10</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Feb. 9</b> , 19 <b>60</b> , and that death occurred at <b>7</b> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Clarksville, Maryland</b> DATE SIGNED <b>2/10/60</b>			
ACTUAL SIGNATURE <b>Charles S. Whitaker</b>		M.D. <b>C. S. Whitaker, M. D.</b>	
PHYSICIAN'S NAME (Type) <b>C. S. Whitaker, M. D.</b>		<b>Clarksville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-13-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls</b>	22d. LOCATION (City, town, or county) (State) <b>Fulton, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higginbotham, Ellicott City, Md</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 15 '60</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Montgomery

Maryland

Howard

Olney

2 days

62 years

Montgomery County General Hosp.

Left home

Mary

John

John

Female

White

Married

19

Montgomery

Maryland

U. S. A.

John (deceased)

Mary (deceased)

No

None

Montgomery Hospital, Olney, Maryland

Montgomery General Hospital

2 days

acute myocardial infarct - 10 days

Feb. 1

Feb. 10

Feb. 10

G. S. Whitaker, M. D.

Clarksville, Maryland

dated 2-12-60

Witness

Witness

F. T. Richardson, M.D., Olney, Md.

2229

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg (Rural)</b>		c. LENGTH OF STAY IN 1b <b>(Rural)</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg (Rural)</b>		d. STREET ADDRESS <b>/</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b>		Middle <b>CLINTON</b>		Last <b>IMES</b>		4. DATE OF DEATH Month <b>Feb.</b>		Day <b>21</b>		Year <b>19 60</b>		9. AGE (In years last birthday) <b>60</b>		IF UNDER 1 YEAR Months <b></b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 12, 1899</b>		9. AGE (In years last birthday) <b>60</b>		IF UNDER 1 YEAR Months <b></b>		IF UNDER 24 HRS. Days <b></b>		Hours <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>John W. Imes</b>		14. MOTHER'S MAIDEN NAME <b>Bertie Thomas</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b></b>		16. SOCIAL SECURITY NO. <b></b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURED DUODENAL ULCER</b> <b>541.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Duodenal Ulcer</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>1 year</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b></b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	
20f. (City or town) <b></b>		(County) <b></b>		(State) <b></b>		21. I certify that I attended the deceased from <b>JAN 1960</b> , 1960, to <b>FEB 21, 1960</b> , that I last saw the deceased alive on <b>FEB 20, 1960</b> , and that death occurred at <b>6:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>544 W MONTGOMERY AVE. ROCKVILLE, MD.</b>		DATE SIGNED <b>2/23/60</b>		ACTUAL SIGNATURE <b>William Frank</b>		PHYSICIAN'S NAME (Type) <b>WILLIAM FRANK, M.D. ROCKVILLE, MD.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/24/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Poplar Grove.</b>		22d. LOCATION (City, town, or county) <b>Poplar Grove, Md.</b>		(State) <b></b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>		ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 25 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2552

(Date)

(Date)

CO. 1000, 1st Div., 1st Regt.

CO. 1000, 1st Div., 1st Regt.

1000, 1st Div., 1st Regt.

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1000, 1st Div., 1st Regt.

1000, 1st Div., 1st Regt.



2230

## CERTIFICATE OF DEATH

Reg. Dist. No.

02177

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>69X-3</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b> d. STREET ADDRESS <b>1611 49th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Phyllis</b> Middle <b>(None)</b> Last <b>Iozzia</b>		4. DATE OF DEATH Month <b>February</b> Day <b>8</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 15, 1949</b>
9. AGE (In years last birthday) <b>10</b>		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min. <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Iozzia</b>		14. MOTHER'S MAIDEN NAME <b>Louise Raffaniello</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory insufficiency</b> <b>195.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic carcinoma of the adrenal cortex</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hepatic decompensation</b>		INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>1 1/2 years</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 7, 1960</b> , to <b>February 8, 1960</b> , that I last saw the deceased alive on <b>February 8, 1960</b> , and that death occurred at <b>3:35A M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John Leeman Lewis Jr.</i>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>JOHN LEEMAN LEWIS, JR., M. D.</b>		DATE SIGNED <b>2/8/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>FEB. 10, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>U. S. NATIONAL</b>		22d. LOCATION (City, town, or county) (State) <b>LONG ISLAND N.Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Rinaldo Funeral Home</i>		24a. REC'D BY REGISTRAR <b>FEB 9 '60</b>	
ADDRESS <b>816 N. J. F. E. N. C.</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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Respiratory Inactivity

2002

Statistical evaluation of the above data

study of

10. *How many people are there in your family?*

221

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02/01/2

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN lb <u>30 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>		d. STREET ADDRESS <u>Rt. #2</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Johnson</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>February</u> Day <u>21</u> Year <u>19 60</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1881</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Albert Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Priscilla Jackson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Florance Johnson Rt. #2, Rockville, Md.</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>464x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchio Phlebothrombosis</u> DUE TO (c) <u>Bronchopneumonia &amp; abscesses</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2-3 weeks</u> <u>4-6 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/21/60</u> , 19 <u>60</u> , to <u>2/21/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/20/60</u> , 19 <u>60</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard A. Yates</u> M.D.		ADDRESS (Street, city or town, state) <u>2/22/60</u>	
PHYSICIAN'S NAME (Type) <u>Richard A. Yates, M.D.</u>		<u>Olney, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/25/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant.</u>		22d. LOCATION (City, town, or county) (State) <u>Norbeck, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Placer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

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-after death.

3580

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>50 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Falls Church</b> <b>83 X 3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>508 Faber Drive</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Arthur</b> Last <b>Johnstone</b>				4. DATE OF DEATH Month <b>February</b> Day <b>29</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 3, 1907</b>		9. AGE (In years last birthday) <b>52</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Washington</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Carl Otto Johnstone</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Swenson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>200.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Reticulum cell sarcoma</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>1 year</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>January 10</b> , 19 <b>60</b> , to <b>February 29</b> 19 <b>60</b> , that I last saw the deceased alive on <b>February 29</b> , 19 <b>60</b> , and that death occurred at <b>3:20 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3/1/60</b> ACTUAL SIGNATURE <b>Harold J. Fallon</b> M.D. <b>National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>HAROLD J. FALLON, M. D.</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/3/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Columbia Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Blac A. Thomas</b> <b>Arlington Funeral Home</b>				24a. REC'D BY REGISTRAR <b>3901 North Fairfax Dr.</b> <b>Arlington, Va.</b>		24b. REGISTRAR'S SIGNATURE <b>DATE MAR 3 '60</b> <b>Arthur S. Kline</b>	

MEDICAL CERTIFICATION

STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
CERTIFICATE OF DEATH

County of Baltimore, State of Maryland

50 days

The Clinical Center, Bethesda, Md., 500 Taylor Drive

Charles Johnson

also while June 3, 1967

F. L. Government Washington

Gail L. Johnson

Annals of the

Transmittable The Clinical Center, Bethesda, Md., Maryland

Referring call persons

February 29 1968  
January 10 1968  
3:30 PM

The Clinical Center  
Laboratory Institute of Health  
Bethesda, Md., Maryland  
HAROLD A. WELLS, M.D.

United States

and North Carolina



## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2232		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>87 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <b>215 Thor Drive</b>			
3. NAME OF DECEASED (Type or print)		First <b>Jo-An</b>		Middle <b>Ellen</b>		Last <b>JONES</b>		4. DATE OF DEATH		Month <b>February</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-9-32</b>		9. AGE (In years lost birthday) <b>27</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ralph JONES</b>						14. MOTHER'S MAIDEN NAME <b>Ellen ERNST</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>1951 to 1953</b>		INFORMANT <b>(H) Laverne L. Jones, same as #2 above</b>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral thrombosis and infarction</b> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>anterior communicating artery (cerebral) aneurysm</b> DUE TO (c) <b>2 mos</b> 2 mos										INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <b>November 24, 1959</b> , to <b>February 19, 1960</b> , that I lost s/he the deceased alive on <b>February 19, 1960</b> , and that death occurred at <b>10:40 A.M.</b> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <b>M. W. Wood MD</b>				ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b>				DATE SIGNED <b>2-20-60</b>			
PHYSICIAN'S NAME (Type) <b>M. W. WOOD, LCDR, MC, USN</b>				Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-23-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>				22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ives Funeral Home</b>						24a. REC'D BY REGISTRAR <b>FEB 24 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000 1st Street, N.W., Washington, D.C.

Final Report of the Commission on the Causes and Prevention of the

Disasters of 1941, Vol. I, Part 1, Chapter 1, Section 1

U. S. Naval Hospital

10:00 A.M.

February 19, 1942

Report of the Commission on the Causes and Prevention of the  
Disasters of 1941, Vol. I, Part 1, Chapter 1, Section 1

1941 to 1942 (H) Lawrence J. Jones, owner and editor

Editor Jones

Wisconsin

U.S.A.

Continued

11-9-38

27

Jones

Wilson

10-21

February

1940

215 Thor Drive

U. S. Naval Hospital

Bellevue (H.M.I.)

87 days

Annals

Virginia

2338

## 2233 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>North Carolina</b> b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>13 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Karen</b> Middle <b>Lee</b> Last <b>JONES</b>				4. DATE OF DEATH Month <b>February</b> Day <b>16</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-13-59</b>	
9. AGE (In years last birthday) <b>2</b> yrs.		IF UNDER 1 YEAR <b>2</b> Months <b>3</b> Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Thomas Semmes JONES</b>				14. MOTHER'S MAIDEN NAME <b>Irene KNIGHTON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
INFORMANT <b>Hospital Records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b> <b>754.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>endocardial fibroelastosis</b> (c) <b>congenital mitral and aortic stenosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>1.5 hours</b> <b>2 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>aspiration pneumonia</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>February 3, 1960</b> to <b>February 16, 1960</b> , that I last saw the deceased alive on <b>February 16, 1960</b> , and that death occurred at <b>1:51 P M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>2-16 59</b>							
ACTUAL SIGNATURE <b>John H. Mazur</b> M.D.							
PHYSICIAN'S NAME (Type) <b>John H. MAZUR, LT, MC, USN</b>				<b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Shipment 2-18-60</b>				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State) <b>Memphis Tennessee</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. H. HINES CO., 2901 14th St., NW, Washington DC</b>				24a. REC'D BY REGISTRAR <b>FEB 18 '60</b>			
ADDRESS				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

Name: John A. Smith  
 Sex: Male  
 Age: 45  
 Date of Birth: 12-18-90  
 Place of Birth: London, England  
 Occupation: Engineer  
 Usual Residence: 123 Main St., New York, N.Y.  
 Cause of Death: Heart Disease  
 Date of Death: 10-15-1945  
 Place of Death: St. Mary's Hospital, New York, N.Y.  
 Physician: Dr. J. H. Jones  
 Burial Place: St. Mary's Cemetery, New York, N.Y.  
 Signature of Physician: [Signature]  
 Signature of Registrar: [Signature]  
 Date of Registration: 10-16-1945  
 Registrar's Office: New York City

This is to certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths for the City and County of New York.  
 Given under my hand and the seal of the Registrar of Deaths for the City and County of New York, this 16th day of October, 1945.  
 Registrar of Deaths  
 City and County of New York

# Item 4 Film G255 2-5-60 et 2142 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

02182

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Takoma Park</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>47X-3</u>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eventide - 700 Hudson Av.</u>		d. STREET ADDRESS <u>3109 Beech St., N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>MARGARET Elizabeth Jones</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-16-1878</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Frederick Co., Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Monroe Eyles</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Elizabeth Stamp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>331X</u>	
17. INFORMANT <u>Gladys Wakefield, 700 Hudson Park</u>		Address <u>Takoma Park</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage (one week)</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Arterial Hypertension</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause lost. <u>Undetermined</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arterio-sclerosis of Senility</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Jan 20</u> , 19 <u>60</u> , to <u>Feb 1</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 31</u> , 19 <u>60</u> , and that death occurred at <u>9:20 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>George L Ball</u> M.D. <u>10620 Georgia Ave. N.W.</u> PHYSICIAN'S NAME (Type) <u>George L Ball</u> <u>Silver Spring Md.</u> <u>Feb 1, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/3/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Salem Cemetery</u>		22d. LOCATION (City, town, or county) <u>Brookville</u> (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u> ADDRESS <u>Ellsworth Armacost-4600 Liberty Hghts. Ave.</u>		24a. REC'D BY REGISTRAR <u>FEB 2 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.











## CERTIFICATE OF DEATH

Reg. Dist. No.

02184

2235

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>7 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b> d. STREET ADDRESS <b>4505 SIGSBEE ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN EDWARD KEMP</b>		4. DATE OF DEATH Month Day Year <b>FEBRUARY 2 1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/28/03</b>
9. AGE (In years lost birthday) yrs. <b>56</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>56</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TRANSIT Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>EDWARD W. KEMP</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET LOUISE DAY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address <b>OLNEY, Mo.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Emboli (Massive)</b> 466X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prostatic Veins Thrombosis</b> DUE TO (c) <b>Pate pulmonary edema</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>year 1955</b> to <b>Feb 2, 1960</b> , that I last saw the deceased alive on <b>2/2, 1960</b> , and that death occurred at <b>9:30 P.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>L. I. Leal</b> M.D. PHYSICIAN'S NAME (Type) <b>L. I. LEAL, M. D.</b> <b>GAITHERSBURG, MARYLAND</b>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial Feb 6 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak Gaithersburg Md</b>	
22d. LOCATION (City, town, or county) (State) <b>Gaithersburg Md</b>		22e. REC'D BY REGISTRAR <b>FEB 5 '60</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Travis H Barber</b>		23b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

223

REPORTED BY

Physician

MONITORING

DATE OF DEATH

PLACE

AGE

DECEASED PERSON'S NAME

DECEASED PERSON'S RESIDENCE

SEX

RACE

EDUCATION

JOBS

CAUSE

IMMEDIATE

USE

HANDWRITING

TESTAMENT IN

REMARKS

HANDWRITING

DEATH OF HEIR

REMARKS

LOCALITY REPORT

Handwritten notes and signatures in the main body of the certificate.

BALTIMORE, MARYLAND

REPORTED BY

DATE OF DEATH

PLACE

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02185

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <span style="float: right;">2143</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>20 days</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u> d. STREET ADDRESS <u>1406 Dale Drive</u>		
3. NAME OF DECEASED (Type or print) <u>Nora Olive Kemp</u> First Middle Last			4. DATE OF DEATH Month <u>2</u> Day <u>1</u> Year <u>1960</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>12-19-74</u>		9. AGE (in years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Produce</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Warren Watson</u>			14. MOTHER'S MAIDEN NAME <u>Martha Taylor</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>257-50-2481</u>		17. INFORMANT Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>900.0 Congestive heart failure</u> DUE TO (b) <u>Broncho pneumonia</u> DUE TO (c) <u>Fracture of ribs (left)</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down stair steps at home</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>3</u> o. m. <u>1-4</u> p. m. <u>1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Silver Spring Monty Md</u>		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschant</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>Feb 1 1960</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB. 4, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MIDWAY CHURCH CEMETERY</u>	
22d. LOCATION (City, town, or county) <u>NEAR LOST MOUNTAIN, MARIETTA, GA.</u>		22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>WARNER E. PIMPHREY, INC., SILVER SPRING, MD.</u>			24a. REC'D BY REGISTRAR DATE <u>FEB 3 '60</u>		
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			24c. REGISTRAR'S SIGNATURE		

TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
JAMES H. HARRIS		Male		45		White		Teacher	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
Baltimore, Md.		Jan 15, 1898		Jan 16, 1943		10:30 AM		Myocardial Infarction	
11. PLACE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF EXAMINER		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF FUNERAL HOME	
Home		Natural		[Signature]		[Signatures]		[Signature]	
16. MEDICAL HISTORY		17. PRESENT ILLNESS		18. POST-MORTEM EXAMINATION		19. TOXICOLOGICAL EXAMINATION		20. OTHER NOTES	
None		Sudden		None		None		None	
21. SIGNATURE OF EXAMINER		22. SIGNATURE OF WITNESSES		23. SIGNATURE OF FUNERAL HOME		24. SIGNATURE OF CORONER		25. SIGNATURE OF JURY	
[Signature]		[Signatures]		[Signature]		[Signature]		[Signatures]	

DEPARTMENT OF HEALTH



2144

## CERTIFICATE OF DEATH

02186

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San. Hospital</i>				d. STREET ADDRESS <i>17503 Flower Ave.</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <i>William Daniel Kimble</i>				4. DATE OF DEATH Month Day Year <i>Feb 2 1960</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Wh.</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>June 29, 1876</i>	
9. AGE (In years last birthday) <i>83</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>N.Y.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>							
13. FATHER'S NAME <i>James D. Kimble</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Lane</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>No</i>		INFORMANT Address <i>Hospital Records</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 570.5 IMMEDIATE CAUSE (a) <i>Broncho-pneumonia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Intestinal Stenosis</i> DUE TO (c) <i>Intestinal Obstruction + toxicity</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <i>one day</i> <i>one week</i> <i>one month</i>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>March</i> , 19 <i>59</i> , to <i>Feb 2</i> , 1960, that I last saw the deceased alive on <i>Feb 2</i> , 1960, and that death occurred at <i>1030</i> PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Takoma Park Md. 7/3/60</i>							
ACTUAL SIGNATURE <i>Robert A Hare</i>				M.D. <i>Robert A Hare, MD</i>			
PHYSICIAN'S NAME (Type) <i>Robert A Hare, MD</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Feb. 6, 1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Morland Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>New York State</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Walters, 254 Canal St NW DC</i>				ADDRESS		24a. REC'D BY REGISTRAR DATE <i>FEB 5 '60</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hare</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2194

John Doe

White

Male

Age

100

Date

1900

Month

10

Day

1900

Place

Home

City

Baltimore

State

Md.

Occupation

Farmer

Education

High School

Religion

Methodist

Married

Wife

Children

3

Signature

Dr. J. H. Smith

Witness

John Doe

Signature

John Doe

Signature

John Doe

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John Doe

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John Doe

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John Doe

2145

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Glady's</u> Middle <u>Bonny</u> Last <u>King</u>		4. DATE OF DEATH Month <u>February</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>fe</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-9-93</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSW</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Wm Bailey</u>	
14. MOTHER'S MAIDEN NAME <u>Emily E. GREGORIE</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>	
16. SOCIAL SECURITY NO. <u>Hospital Record</u>		17. INFORMANT <u>Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> <u>incuratory collapse.</u> DUE TO (b) <u>cerebral hemorrhage.</u> DUE TO (c) <u>cerebral arteriosclerosis.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 hours.</u> <u>8 days.</u> <u>indefinite.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-30-</u> 19 <u>60</u> to <u>2-7-</u> 19 <u>60</u> that I last saw the deceased alive on <u>2-7-</u> 19 <u>60</u> , and that death occurred at <u>6:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Seruch T. Kimble.</u>		ADDRESS (Street, city or town, state) <u>929 Plashing Drive</u> DATE SIGNED <u>2-7-60</u>	
PHYSICIAN'S NAME (Type) <u>SERUCH T. KIMBLE</u>		<u>Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/10/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 9 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

9142

1

REPORTED BY: [illegible]  
DATE: [illegible]  
PLACE: [illegible]  
CITY: [illegible]  
STATE: [illegible]  
COUNTRY: [illegible]

## CERTIFICATE OF DEATH

02188

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u> 1655.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>				d. STREET ADDRESS <u>2123 Guilford Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Krieg</u> Baby Boy Middle <u>Boy</u> Last <u>Boy</u>				4. DATE OF DEATH Month <u>2</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>Boy</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/22/60</u>	
9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.		IF UNDER 24 HRS. Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Norbert Jack Krieg</u>				14. MOTHER'S MAIDEN NAME <u>Ingeborg Wildruth Koepfel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mother - 2123 Guilford Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2:20pm Feb 22 1960</u> , to <u>2/24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/24</u> , 19 <u>60</u> , and that death occurred at <u>8:30p.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. H. Diamond</u>				ADDRESS (Street, city or town, state) <u>8224 Georgia Ave., S.S., Md.</u> DATE SIGNED <u>2/25/60</u>			
PHYSICIAN'S NAME (Type) <u>H. H. Diamond, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Feb. 25</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium &amp; Hospital, Takoma Park, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M.D. Washington San. &amp; Hosp.</u>				24a. REC'D BY REGISTRAR <u>FEB 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hare</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2075291XVI

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15



## CERTIFICATE OF DEATH

Reg. Dist. No.

02189

2235

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) d. STATE <b>Maryland</b> <b>COUNTY</b> <b>St. Mary's</b> <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney LaPlata Indian Head</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Brooke Grove Nursing Home</b>		d. STREET ADDRESS <b>08X-2</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Joseph William Kronk</b>		4. DATE OF DEATH Month Day Year <b>2 18 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 16, 1873</b>
9. AGE (In years last birthday) <b>86 7/8</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Blacksmith</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Louis M. Kronk</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Barnes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>Spanish-American War none</b>	
17. INFORMANT <b>Carlin M. Cronk, 10 First St., Indianhead, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolus</b> <b>465X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>15 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/13</b> , 19 <b>55</b> , to <b>2/18</b> , 19 <b>60</b> that I last saw the deceased alive on <b>2/18</b> , 19 <b>60</b> , and that death occurred at <b>12:15 P.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. D. Bonifant</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>Sandy Spring, Md. 2/18/60</b>	
PHYSICIAN'S NAME (Type) <b>A. D. Bonifant, M.D.</b>		<b>Sandy Spring, Maryland 2.18.60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/21/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Park Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Marbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Archart</b>		24a. REC'D BY REGISTRAR <b>FEB 23 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ORIGINAL COPY

333

ESTIMATE OF DEATH

4213

Name		Age		Sex		Race		Religion		Marital Status		Occupation		Education		Date of Birth		Date of Death		Cause of Death		Place of Death		Time of Death		Signature		Date	
John Doe		35		Male		White		Catholic		Married		Teacher		High School		1945		1985		Heart Disease		Home		10:00 AM		John Doe		1985	
Jane Doe		32		Female		White		Catholic		Married		Homemaker		High School		1945		1985		Heart Disease		Home		10:00 AM		Jane Doe		1985	
Robert Doe		38		Male		White		Catholic		Married		Engineer		College		1945		1985		Heart Disease		Home		10:00 AM		Robert Doe		1985	
Mary Doe		30		Female		White		Catholic		Married		Nurse		College		1945		1985		Heart Disease		Home		10:00 AM		Mary Doe		1985	
James Doe		33		Male		White		Catholic		Married		Doctor		College		1945		1985		Heart Disease		Home		10:00 AM		James Doe		1985	
Elizabeth Doe		31		Female		White		Catholic		Married		Teacher		High School		1945		1985		Heart Disease		Home		10:00 AM		Elizabeth Doe		1985	
Michael Doe		36		Male		White		Catholic		Married		Engineer		College		1945		1985		Heart Disease		Home		10:00 AM		Michael Doe		1985	
Susan Doe		29		Female		White		Catholic		Married		Nurse		College		1945		1985		Heart Disease		Home		10:00 AM		Susan Doe		1985	
David Doe		34		Male		White		Catholic		Married		Teacher		High School		1945		1985		Heart Disease		Home		10:00 AM		David Doe		1985	
Patricia Doe		37		Female		White		Catholic		Married		Homemaker		High School		1945		1985		Heart Disease		Home		10:00 AM		Patricia Doe		1985	
Christopher Doe		32		Male		White		Catholic		Married		Engineer		College		1945		1985		Heart Disease		Home		10:00 AM		Christopher Doe		1985	
Margaret Doe		30		Female		White		Catholic		Married		Nurse		College		1945		1985		Heart Disease		Home		10:00 AM		Margaret Doe		1985	
Daniel Doe		35		Male		White		Catholic		Married		Teacher		High School		1945		1985		Heart Disease		Home		10:00 AM		Daniel Doe		1985	
Barbara Doe		33		Female		White		Catholic		Married		Homemaker		High School		1945		1985		Heart Disease		Home		10:00 AM		Barbara Doe		1985	
Steven Doe		31		Male		White		Catholic		Married		Engineer		College		1945		1985		Heart Disease		Home		10:00 AM		Steven Doe		1985	
Kathleen Doe		29		Female		White		Catholic		Married		Nurse		College		1945		1985		Heart Disease		Home		10:00 AM		Kathleen Doe		1985	
Joseph Doe		36		Male		White		Catholic		Married		Teacher		High School		1945		1985		Heart Disease		Home		10:00 AM		Joseph Doe		1985	
Christine Doe		34		Female		White		Catholic		Married		Homemaker		High School		1945		1985		Heart Disease		Home		10:00 AM		Christine Doe		1985	
Anthony Doe		32		Male		White		Catholic		Married		Engineer		College		1945		1985		Heart Disease		Home		10:00 AM		Anthony Doe		1985	
Dorothy Doe		30		Female		White		Catholic		Married		Nurse		College		1945		1985		Heart Disease		Home		10:00 AM		Dorothy Doe		1985	
Kenneth Doe		35		Male		White		Catholic		Married		Teacher		High School		1945		1985		Heart Disease		Home		10:00 AM		Kenneth Doe		1985	
Betty Doe		33		Female		White		Catholic		Married		Homemaker		High School		1945		1985		Heart Disease		Home		10:00 AM		Betty Doe		1985	
Gregory Doe		31		Male		White		Catholic		Married		Engineer		College		1945		1985		Heart Disease		Home		10:00 AM		Gregory Doe		1985	
Sandra Doe		29		Female		White		Catholic		Married		Nurse		College		1945		1985		Heart Disease		Home		10:00 AM		Sandra Doe		1985	
Timothy Doe		36		Male		White		Catholic		Married		Teacher		High School		1945		1985		Heart Disease		Home		10:00 AM		Timothy Doe		1985	
Debra Doe		34		Female		White		Catholic		Married		Homemaker		High School		1945		1985		Heart Disease		Home		10:00 AM		Debra Doe		1985	
Eric Doe		32		Male		White		Catholic		Married		Engineer		College		1945		1985		Heart Disease		Home		10:00 AM		Eric Doe		1985	
Cynthia Doe		30		Female		White		Catholic		Married		Nurse		College		1945		1985		Heart Disease		Home		10:00 AM		Cynthia Doe		1985	
Douglas Doe		35		Male		White		Catholic		Married		Teacher		High School		1945		1985		Heart Disease		Home		10:00 AM		Douglas Doe		1985	
Katherine Doe		33		Female		White		Catholic		Married		Homemaker		High School		1945		1985		Heart Disease		Home		10:00 AM		Katherine Doe		1985	
Nathan Doe		31		Male		White		Catholic		Married		Engineer		College		1945		1985		Heart Disease		Home		10:00 AM		Nathan Doe		1985	
Olivia Doe		29		Female		White		Catholic		Married		Nurse		College		1945		1985		Heart Disease		Home		10:00 AM		Olivia Doe		1985	
Peter Doe		36		Male		White		Catholic		Married		Teacher		High School		1945		1985		Heart Disease		Home		10:00 AM		Peter Doe		1985	
Rebecca Doe		34		Female		White		Catholic		Married		Homemaker		High School		1945		1985		Heart Disease		Home		10:00 AM		Rebecca Doe		1985	
Samuel Doe		32		Male		White		Catholic		Married		Engineer		College		1945		1985		Heart Disease		Home		10:00 AM		Samuel Doe		1985	
Teresa Doe		30		Female		White		Catholic		Married		Nurse		College		1945		1985		Heart Disease		Home		10:00 AM		Teresa Doe		1985	
Vincent Doe		35		Male		White		Catholic		Married		Teacher		High School		1945		1985		Heart Disease		Home		10:00 AM		Vincent Doe		1985	
Wendy Doe		33		Female		White		Catholic		Married		Homemaker		High School		1945		1985		Heart Disease		Home		10:00 AM		Wendy Doe		1985	
Xavier Doe		31		Male		White		Catholic		Married		Engineer		College		1945		1985		Heart Disease		Home		10:00 AM		Xavier Doe		1985	
Yvonne Doe		29		Female		White		Catholic		Married		Nurse		College		1945		1985		Heart Disease		Home		10:00 AM		Yvonne Doe		1985	
Zachary Doe		36		Male		White		Catholic		Married		Teacher		High School		1945		1985		Heart Disease		Home		10:00 AM		Zachary Doe		1985	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2237 CERTIFICATE OF DEATH

Reg. Dist. No.

02190

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery Co.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>22</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash. D.C.</u> COUNTY <u>47X-3</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> d. STREET ADDRESS <u>3815 Calvert St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>RACHEL L LAMBERT</u> First Middle Last <b>5. SEX</b> <u>FEMALE</u> <b>6. COLOR OR RACE</b> <u>WHITE</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>12/3/1863</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>96</u> yrs.		<b>4. DATE OF DEATH</b> Month <u>2</u> Day <u>20</u> Year <u>1960</u> <b>9. AGE</b> (In years last birthday) <u>96</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House wife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>—</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Roland John</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Lockan, Mary</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u> <b>16. SOCIAL SECURITY NO.</b> <u>No</u> <b>17. INFORMANT</b> <u>LEROY R. SWEETMAN</u> Address <u>3815 Calvert NW</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>433.1</u> DUE TO (b) <u>Auricular Fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Senile Sclerotic myocarditis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>—</u> <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>—</u> <b>20f. (City or town)</b> (County) (State)		<b>21. I certify that I attended the deceased from</b> <u>December 19, 1948</u> to <u>Feb. 20, 1960</u> , that I last saw the deceased alive on <u>Feb. 19, 1960</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3141-34th St NW</u> DATE SIGNED <u>Wash DC</u> ACTUAL SIGNATURE <u>J. A. Gannon</u> M.D. PHYSICIAN'S NAME (Type) <u>JAMES A. GANNON</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>2-22-60</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Congressional Cem</u> <b>22d. LOCATION</b> (City, town, or county) (State) <u>Washington DC</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. Don LeVol</u> ADDRESS <u>2224 - Wisconsin Ave NW, D.C.</u> <b>24a. REC'D BY REGISTRAR</b> DATE <u>FEB 23 '60</u> <b>24b. REGISTRAR'S SIGNATURE</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2165 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02191

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase Md.</u>		c. LENGTH OF STAY IN 1b <u>years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>58 Cherry Chase, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7105 46th St., Cherry Chase, Md.</u>			d. STREET ADDRESS <u>7105 46th St., Cherry Chase Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>Mary</u> Last <u>Lappin</u>			4. DATE OF DEATH Month <u>2</u> Day <u>7</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1866</u>	9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>7</u> Hours <u>19</u> Min. <u>60</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>	
13. FATHER'S NAME <u>John McCristel</u>			14. MOTHER'S MAIDEN NAME <u>Frances M. Byrne</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Katherine Hutchinson, Daughter</u> Address <u>7105 46th St., Cherry Chase Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>year</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/9/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Washington, D. C.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>			ADDRESS <u>Bethesda, Maryland</u>		
24a. REC'D BY REGISTRAR <u>FEB 9 '60</u>			24b. REGISTRAR'S SIGNATURE <u>Curtis &amp; Lewis</u>		







may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02193

2238

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>District of Columbia</b> COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>14 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Mae</b> Last <b>LEDoux</b>				4. DATE OF DEATH Month <b>February</b> Day <b>23</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-4-64</b>	
9. AGE (In years last birthday) <b>95</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>12</b>		IF UNDER 24 HRS. Hours <b>12</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>John HOWE</b>				14. MOTHER'S MAIDEN NAME <b>Frances ROBERTSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>no</b>			
17. INFORMANT <b>(Son) Lenderville LEDoux</b>				Address <b>Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 794X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>fracture/simple right hip</b> DUE TO (c) <b>General old age and debility</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>12 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>9 February</b> , 19 <b>60</b> , to <b>23 February</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>23 February</b> , 19 <b>60</b> , and that death occurred at <b>12:12P</b> , M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda Md.</b> DATE SIGNED <b>2-23-60</b> ACTUAL SIGNATURE <b>Kenneth S. Spence</b> PHYSICIAN'S NAME (Type) <b>K.F. SPENCE LT MC USN</b> <b>U.S. Naval Hospital, Bethesda Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>2-26-60</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>				22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee's 4th &amp; Massachusetts Ave NW WDC</b>				24a. REC'D BY REGISTRAR <b>FEB 29 '60</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knapp</b>							

2855

(L-101) 118100

U.S. Naval Hospital, Bethesda, Md.

2000-01-01

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110

3.5

11/20/2003 11:55:11 AM

### Abbreviations

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2147 CERTIFICATE OF DEATH

Reg. Dist. No.

02194

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN It <u>25 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. &amp; Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
				d. STREET ADDRESS <u>718 Pershing Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Merle</u> Last <u>Lerch, SR</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-22-93</u>	
				9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proof Reader</u>				10c. KIND OF BUSINESS OR INDUSTRY <u>Govt. Printing Office</u>			
13. FATHER'S NAME <u>EDWARD P. Lerch</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Young</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-38-3503</u>		17. INFORMANT <u>W.S. Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Coronary Occlusion</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>24 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct 6</u> , 19 <u>57</u> , to <u>Feb 25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 24</u> , 19 <u>60</u> , and that death occurred at <u>9:25 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Merrill M. Cross</u>				ADDRESS (Street, city or town, state) <u>8248 Georgia ave. Silver Spring, Md.</u> DATE SIGNED <u>2/25/60</u>			
PHYSICIAN'S NAME (Type) <u>MERRILL M. CROSS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>ENTOMBMENT</u>		22b. DATE THEREOF <u>2/29/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN MAUSOLEUM</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>FEB 29 '60</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fraws</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

2121

## CERTIFICATE OF DEATH

02196

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>8 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>12,903 Hathaway Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CARRIE</b> Middle <b>BELLE</b> Last <b>LEWIS</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>23</b> Year <b>19 60</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/24/66</b>
9. AGE (In years lost birthday) <b>93</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ROBERT M. DAWSON</b>		14. MOTHER'S MAIDEN NAME <b>ROBERTA C. MINTON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mrs. Estelle Hodgson, 12,903 Hathaway Drive Silver Spring, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> 522x DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Hypostatic Pneumonia</b> DUE TO <b>Senility</b> (c) <b>Senility</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/26</b> , 19 <b>56</b> , to <b>2/23</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>2/1</b> , 19 <b>60</b> , and that death occurred at <b>12:45 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>9321 Georgia Ave. Silver Spring Md</b> DATE SIGNED <b>9321</b>			
ACTUAL SIGNATURE <b>N.T. Lucius</b>		M.D. <b>9321</b>	
PHYSICIAN'S NAME (Type) <b>N.T. LUCIUS</b>		<b>Silver Spring Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2/26/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>UNION CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>ALEXANDRIA, VIRGINIA</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond W. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>FEB 25 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kram</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1151

DECEASED		DATE OF DEATH		PLACE OF DEATH	
NAME		AGE		SEX	
RACE		RELIGION		MARRIAGE	
OCCUPATION		EDUCATION		SCHOOLING	
BIRTH		DEATH		BURIAL	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2172

## CERTIFICATE OF DEATH

Reg. Dist. No.

02195

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>WASH. D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens JAN</u>				d. STREET ADDRESS <u>2942 NEWARK ST. N.W.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Florence E. L'Hormedieu</u>				4. DATE OF DEATH Month Day Year <u>2 2 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-20-1872</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bank</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Brooklyn, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm Cornwell</u>				14. MOTHER'S MAIDEN NAME <u>Mary Reguay</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>578-10-1697</u>		17. INFORMANT <u>Mr. Samuel J. L'Hormedieu, Wash DC</u> Address <u>2734 McKinley St NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>12 months</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>decubital ulcers, senility</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb 2</u> , 1950, to <u>Feb 2</u> , 1960, that I last saw the deceased alive on <u>2 February</u> , 1960, and that death occurred at <u>1240 P</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>4817 Lenox Ave. NW Wash DC</u>				DATE SIGNED <u>Feb 8 '60</u>			
ACTUAL SIGNATURE <u>Joseph H. Cowan</u> M.D.							
PHYSICIAN'S NAME (Type) <u>JOSEPH H. COWAN</u>				<u>WASHINGTON 8 D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/5/60</u>		<u>Angel Hall Cemetery</u>		<u>Hamlet Place Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home Wash. D.C.</u>				24. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>FEB 8 '60</u>		<u>Arthur S. Fennell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02197

2239

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> o. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brook Grove Foundation</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sophia</u> First <u>M</u> Middle <u>Lindner</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 18, 1872</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <u>87</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
13. FATHER'S NAME <u>August Voigt</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. MOTHER'S MAIDEN NAME <u>Sunderman</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs R.M. Seebold</u> Address <u>14 Hilltop Rd. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>481X " Virus Influenza (Epidemic)</u> DUE TO <u>Fracture left femur</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gen. art. Sclerosis + Sensitivity</u> DUE TO (c) <u>8 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 weeks</u> <u>8 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3 Feb.</u> , 19 <u>60</u> , to <u>8 Feb.</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8 Feb.</u> , 19 <u>60</u> , and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Boskey Ziegler</u> M.D.		ADDRESS (Street, city or town, state) <u>Olney, Md.</u>	
PHYSICIAN'S NAME (Type) <u>JOHN BOSKEY ZIEGLER</u>		DATE SIGNED <u>8 Feb 60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 10, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters, 254 Carroll St NW D.C.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>FEB 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	



## CERTIFICATE OF DEATH

Reg. Dist. No. 215

02198

2240

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>26 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lela</b> Middle <b>Macie</b> Last <b>LINGLE</b>				4. DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-3-13</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Florida</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>			
13. FATHER'S NAME <b>Otha BROWN</b>				14. MOTHER'S MAIDEN NAME <b>Dollie Horn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>266-14-9661</b>			
17. INFORMANT <b>(H) F. J. Lingle, same as #2 above</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of The Thyroid</b> DUE TO (b) <b>194X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>6 1/2 yrs.</b> INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>January 9</b> , 19 <b>60</b> , to <b>February 4</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>February 4</b> , 19 <b>60</b> , and that death occurred at <b>10:35 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R. G. Galbraith</b>				ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>2-4-60</b>			
PHYSICIAN'S NAME (Type) <b>R. G. GALBRAITH, LT, MC, USN</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment 2-5-60</b>				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY <b>Baptist Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Live Oak Florida</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chery Chase Funeral Home</b>				24a. REC'D BY REGISTRAR <b>FEB 8 60</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur J. Smith</b>				24c. ADDRESS <b>Chevy Chase Funeral Home, 5103 Wisc. Ave., NW, WDC</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Place of birth: [illegible]  
6. Date of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

11. Name of informant: [illegible]  
12. Address of informant: [illegible]  
13. Signature of informant: [illegible]  
14. Date of completion: [illegible]  
15. Registrar's Office: [illegible]  
16. City: [illegible]  
17. State: [illegible]  
18. County: [illegible]



# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 2122 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>29 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		d. STREET ADDRESS <u>10000 Southerland Dr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>10000 Southerland Dr</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ella</u> Last <u>Lynn</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>26</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-10-1892</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>homework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dr</u>		11. BIRTHPLACE (State or foreign country) <u>Dr</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>							
13. FATHER'S NAME <u>Henry Rogers</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Beach</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Ira K. Churns</u>		Address <u>706 Chestnut St</u> <u>Frederick, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>2-26-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/1/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glennwood</u>		22d. LOCATION (City, town, or country) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR <u>W.W. Chambers Co. Inc.</u>				ADDRESS <u>3072 M St. NW</u> <u>Wash, DC</u>			
24a. REC'D BY REGISTRAR <u>Arthur S. Kinn</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>			

MEDICAL CERTIFICATION

2

82199



## 2148 CERTIFICATE OF DEATH

Reg. Dist. No.

02200

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>				c. LENGTH OF STAY IN 1b <u>23 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>075 Wash Ave &amp; Hosp</u>				d. STREET ADDRESS <u>18003 Ark Crest Dr</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Simon</u> Middle <u>(NMN)</u> Last <u>Malinsky</u>				4. DATE OF DEATH Month <u>2</u> - Day <u>17</u> - Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-27-76</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher Ret</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Amer. USA</u>							
13. FATHER'S NAME <u>GERSHAN Malinsky</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>577-03-9863</u>			
17. INFORMANT <u>1st Chast in Hosp</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>terminal heart failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2/12/60</u> to <u>2/17/60</u> that I last saw the deceased alive on <u>2/17</u> , 19 <u>60</u> , and that death occurred at <u>6:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur J. Wilets</u> M.D.				ADDRESS (Street, city or town, state) <u>909 FERSHING DR. SSp9 Md.</u> DATE SIGNED <u>2/17/60</u>			
PHYSICIAN'S NAME (Type) <u>ARTHUR J. WILETS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>2/19/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beth Shalom Cnm</u>	
22d. LOCATION (City, town, or county) <u>DC</u>				(State) <u></u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Soldberg Funeral Home</u> ADDRESS <u>4217 94th Ave D.C.</u>				24a. REC'D BY REGISTRAR <u>FEB 19 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Wilets</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

02201

2241

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>19 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Willie</u> First <u>Seddon</u> Middle <u>Marston</u> Last		4. DATE OF DEATH Month <u>Feb.</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 13-1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Etna Mills - Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Patrick Henry Cubank</u>		14. MOTHER'S MAIDEN NAME <u>Sally Herr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>Hosp. Records</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE SUBARACHNOID HEMM.</u> 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gen. Arteriosclerosis + Scurvy</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 21-1958</u> , to <u>26 Feb-1960</u> , that I last saw the deceased alive on <u>26 Feb-1960</u> , and that death occurred at <u>10:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Boskey Ziegler</u> M.D.		ADDRESS (Street, city or town, state) <u>OLNEY, MD</u> DATE SIGNED <u>26 Feb 60</u>	
PHYSICIAN'S NAME (Type) <u>JOHN BOSKEY ZIEGLER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-29-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Massanutten</u>		22d. LOCATION (City, town, or county) (State) <u>Woodstock VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W L Dellinger</u>		ADDRESS <u>Woodstock, Va</u>	
24a. REC'D BY REGISTRAR <u>DATE FEB 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2173

## CERTIFICATE OF DEATH

02202

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> o. COUNTY <b>Montgomery</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>			c. LENGTH OF STAY IN b <b>57</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Rest Home</b>				/ d. STREET ADDRESS <b>5115 Wessling Lane</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Ida</b> Middle <b>F.</b> Last <b>McCarthy</b>				<b>4. DATE OF DEATH</b> Month <b>Feb</b> Day <b>2</b> Year <b>19 60</b>					
<b>5. SEX</b> <b>F</b>		<b>6. COLOR OR RACE</b> <b>W</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Sept. 7, 1884</b>		<b>9. AGE</b> (In years last birthday) <b>75</b> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maine</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>William Sweeney</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Sarah Logan</b>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>William J. McCarthy, Jr. - Item #2 - Son</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic - Carcinomatosis (Breast)</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b>  <b>30 hrs.</b>  <b>two years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify</b> that I attended the deceased from <b>June 19 55</b> to <b>February 2 19 60</b> , that I last saw the deceased alive on <b>February 1 19 60</b> , and that death occurred at <b>5:40 P.M.</b> from the causes and on the date stated above.									
<b>ACTUAL SIGNATURE</b> <i>Frank Jagers Jr. M.D.</i>				<b>ADDRESS</b> (Street, city or town, state) <b>5707 WISCONSIN AVE</b>				<b>DATE SIGNED</b> <b>2/2/60</b>	
<b>PHYSICIAN'S NAME</b> (Type) <b>Frank Jagers Jr. M.D.</b>				<b>CHEVY CHASE 15, Md.</b>					
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Bur-Trans.</b>			<b>22b. DATE THEREOF</b> <b>2-4-60</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Pleasant Cemetery</b>			<b>22d. LOCATION</b> (City, town, or county) (State) <b>Bangor, Maine</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert A. Pumphrey, Bethesda, Maryland</b>						<b>24a. REC'D BY REGISTRAR</b> <b>DATE FEB 8 '60</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kious</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon between pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

02203  
215

2242

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>			c. LENGTH OF STAY IN lb <b>34 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				d. STREET ADDRESS <b>10505 Malone Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Adrey</b> Last <b>MC CULLAH</b>				4. DATE OF DEATH Month <b>February</b> Day <b>25</b> Year <b>1960</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-23-07</b>		
9. AGE (In years lost birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Fred GANT</b>				14. MOTHER'S MAIDEN NAME <b>Evelyn GARBER</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>(Husband) Harry F. MC CULLAH Same as #2</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, breast with metastases</b> <b>170X</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>5 mos.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>22 January</b> , 19 <b>60</b> to <b>25 February</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>25 February</b> , 19 <b>60</b> , and that death occurred at <b>2:10P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda Md. 2-26-60</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>E.J. Rupnik</b> M.D. <b>U.S. Naval Hospital, Bethesda Md. 2-26-60</b> PHYSICIAN'S NAME (Type) <b>E.J. RUPNIK LCDR MC USN</b> <b>U.S. Naval Hospital, Bethesda Md.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-1-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>S.H. HINES</b> ADDRESS <b>2901 14th St. N.W. Washington D.C.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 29 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

Registration District

County

Age

Sex

Marital Status

Place of Birth

U.S. Naval Hospital, Bethesda, Md.

NO. OF DEATH

DATE

TIME

Place

Time

10-23-01

25

Residence

Home

Pennsylvania

First Cause

Myocardial Infarction

(Decedent) Name: F. M. OULAH, Home No. 12

*at home with wife and children*

32 January

32 January

32 February

U.S. Naval Hospital, Bethesda, Md.

*at home*

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

Washington, D.C.

Washington, D.C.

2-1-01

U.S. Naval Hospital, Bethesda, Md.

<div style="display: flex; justify-content: space-between;"> <span>Item 18 Film 259 3-31-60</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18</span> <span>02204</span> </div> <div style="display: flex; justify-content: space-between;"> <span>2243</span> <span>CERTIFICATE OF DEATH</span> <span>Reg. Dist. No. 215</span> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>2 days</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> <span style="float: right;">b. COUNTY <b>Arlington</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b> <span style="float: right;">83 x - 3</span>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>					d. STREET ADDRESS <b>3916 4th Street N.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Estella</b> Middle <b>Mary</b> Last <b>MC DERMOTT</b>					<b>4. DATE OF DEATH</b> Month <b>February</b> Day <b>15</b> Year <b>1960</b>				
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>Caucasian</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>5-20-76</b>		<b>9. AGE</b> (In years last birthday) <b>83</b> yrs.	
						<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>- - - -</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Wisconsin</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>William BUSBY</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Bridget WELSH</b>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> [Yes, no, or unknown] <b>No</b> (If yes, give war or dates of service)					<b>16. SOCIAL SECURITY NO.</b> <b>None</b>				
<b>INFORMANT</b> Address <b>Clarksville, Md.</b> <b>(D) Katherine Herrold, Trotter Rd. Rt. 29</b>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>10th line of colon with</b> <b>572.1</b> DUE TO <b>Diverticulosis and diverticulitis with abscess</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Perforation of sigmoid and per perforation of descending</b> (c) <b>Peritonitis</b> <b>colon.</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Atherosclerotic heart disease</b>									
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that I attended the deceased from</b> <b>February 13, 1960</b> , <b>to</b> <b>February 15, 1960</b> , <b>that I last saw the deceased alive on</b> <b>February 15, 1960</b> , <b>and that death occurred at</b> <b>8:57A</b> , <b>from the causes and on the date stated above.</b>									
<b>ACTUAL SIGNATURE</b> <b>R. G. Galbraith, Jr.</b>					<b>ADDRESS</b> (Street, city or town, state) <b>U. S. Naval Hospital</b> <b>DATE SIGNED</b> <b>2-15-60</b>				
<b>PHYSICIAN'S NAME (Type)</b> <b>R. G. GALBRAITH, JR., LT, MC, USN</b> <b>Bethesda 14, Maryland</b>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial-Shipment</b>			<b>22b. DATE THEREOF</b> <b>2-16-60</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Holy Cross</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Fargo</b> <b>No. Dakota</b>		
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>ADDRESS</b> <b>Va.</b> <b>Ives Funeral Home, 2847 Wilson Blvd. Arlington,</b>					<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>FEB 16 '60</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kincaid</b>		



CRIMINAL CASE OF DEATH

2043

Virginia

Allegheny

1910 and 1911

NO. 12,000

2-20-78

Missouri

Religious Union

(D)

February 13 60 February 12 60

8:30A

U. S. Naval Hospital

February 14, 1911

A. G. GILBERT, JR., U. S. N.

July 1908

2-10-60

Evening News, 2007, 11th St., Baltimore



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 Film G258 3-8-60 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

02205

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown</b> c. LENGTH OF STAY IN lb  d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Marylander Nursing Home</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Montgomery</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b> d. STREET ADDRESS <b>1609 Sanford Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Margaret Isabel McElroy</b> First Middle Last <b>Female</b> <b>White</b> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>57-32-7101</b> <b>Unknown</b>		<b>4. DATE OF DEATH</b> Month <b>February</b> Day <b>22</b> Year <b>1960</b> <b>7/5/1873</b> <b>86</b> yrs. <b>9</b> Months <b>17</b> Days <b>17</b> Hours <b>17</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b> <b>13. FATHER'S NAME</b> <b>Ben F. Sheffer, Benjamin F.</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>-----</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Pennsylvania</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>US</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>INFORMANT</b> <b>Mary Elkin, Margaret</b> Address <b>Miss Olive McElroy-daughter-same 2d</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b> DUE TO <b>334X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>atherosclerosis</b> DUE TO (c) <b>arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b> <b>1 year</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Right hemiplegia</b>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that I attended the deceased from</b> <b>March 19 59</b> , to <b>Feb 22, 1960</b> , that I last saw the deceased alive on <b>Feb 22, 1960</b> , and that death occurred at <b>E. P. M.</b> from the causes and on the date stated above. <b>ADDRESS</b> (Street, city or town, state) <b>Dawsonville, P.O. Bayds, Md</b> <b>DATE SIGNED</b> <b>ACTUAL SIGNATURE</b> <b>John J. Fawcett</b> <b>M.D.</b> <b>Feb 23 1960</b> <b>PHYSICIAN'S NAME (Type)</b> <b>John J. Fawcett</b> <b>Dawsonville, Md.</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Bur-Transit 2/24/60</b>		<b>22b. DATE THEREOF</b> <b>2/24/60</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Homewood Cemetery</b>		<b>22d. LOCATION (City, town, or county) (State)</b> <b>Pittsburgh, Pennsylvania</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert A. Pumphrey</b> <b>Bethesda, Maryland</b>		<b>24a. REC'D BY REGISTRAR</b> <b>FEB 26 '60</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Evans</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02206

Reg. Dist. No.

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>P.G.</i> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ednor</i>		c. LENGTH OF STAY IN 1b <i>9 mo</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		1658-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Belmont Nursing Home</i>				d. STREET ADDRESS <i>7400 25th Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> A. Middle <i>McKechnie</i> Last <i>McKechnie</i>				4. DATE OF DEATH Month <i>Feb</i> Day <i>9</i> Year <i>1960</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1-26-1880</i>	
9. AGE (In years last birthday) <i>80 yrs.</i>		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>		IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of life. If retired, state so) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>		11. BIRTHPLACE (State or foreign country) <i>Ill</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Joseph Moran</i>				14. MOTHER'S MAIDEN NAME <i>Mary Lynn</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>				16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>Nursing Home Record - Sister 1</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Coronary occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arterio sclerosis</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschant</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>FRANK J. Broschant</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>TRANS. &amp; BURIAL 2/9/60</i>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <i>CALVARY CEMETERY</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Ziska</i>				ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR <i>FEB 11 '60</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>		DATE SIGNED <i>2-9-60</i>	
22d. LOCATION (City, town, or county) (State) <i>EVANSTON, COOK COUNTY, ILLINOIS</i>							



## CERTIFICATE OF DEATH

02207

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Buchanan</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda Maryland</i>		c. LENGTH OF STAY IN lb <i>(4 years)</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Congressional Manor Santurin</i>		d. STREET ADDRESS <i>9200 Wisconsin Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>Helen</i> Middle <i>V</i> Last <i>McLeish</i>		4. DATE OF DEATH Month <i>2</i> Day <i>23</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/18/1867</i>
9. AGE (In years last birthday) <i>91 1/2</i> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>U.S. Government</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Government</i>	11. BIRTHPLACE (State or foreign country) <i>Buchanan, Virginia</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>James S. Martin</i>	
14. MOTHER'S MAIDEN NAME <i>Finney</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	
16. SOCIAL SECURITY NO. <i>—</i>		INFORMANT <i>Lee Martin</i> Address <i>5521 Columbia Ave NW Wash. D.C.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332 x</i> DUE TO <i>Usual Pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral Thrombosis with</i> (c) <i>right sided facial paralysis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Semility</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>3 days</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 12, 1956</i> to <i>Feb 23, 1960</i> that I last saw the deceased alive on <i>Feb 22, 1960</i> and that death occurred at <i>6:40 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Philip E. Jones</i> M.D.		ADDRESS (Street, city or town, state) <i>918 Ellsworth Drive Silver Spring, Md</i> DATE SIGNED <i>2/23/60</i>	
PHYSICIAN'S NAME (Type) <i>Philip E. Jones</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>2/25/60</i>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NAT CENT. ARLINGTON VA.</i>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. W. Lees</i> ADDRESS <i>Wash. D.C.</i>		24a. REC'D BY REGISTRAR <i>FEB 25 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

02501

CERTIFICATE OF DEATH



*[Faint, illegible text, likely a death certificate form with fields for name, date, and cause of death.]*





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02208

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Jay</u> Last <u>Meister</u>				4. DATE OF DEATH Month <u>2</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-3-09</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WIREMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>self</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>(Unknown)</u>				14. MOTHER'S MAIDEN NAME <u>Sarah (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-10-7892</u>			
17. INFORMANT <u>Mrs Alice Eliz. Meister - Wife</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Paul J. Bronhart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschalt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/26/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Pickner &amp; Sons - Balto.</u>				24a. REC'D BY REGISTRAR <u>DATE 2-25-60</u>		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



CERTIFICATE OF DEATH

02209

Reg. Dist. No.

2247

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, MD.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C.</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>5623 First St. N.W.</u>	

3. NAME OF DECEASED (Type or print) <u>Willie</u> First <u>MERRITT</u> Middle Last		4. DATE OF DEATH <u>Feb. 17</u> 19 <u>60</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 10, 1884</u> 15 yrs.
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Georgia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13. FATHER'S NAME <u>ALEX JAMES</u>	14. MOTHER'S MAIDEN NAME <u>FANNIE BUCK</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>175 MARGARET CHEASON</u>	INFORMANT Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary atelectasis</u> 570.2 DUE TO <u>Aspiration of intestinal contents</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mesenteric venous thrombosis-infection</u> DUE TO (c) <u>4 days</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary stenosis - mitral insufficiency - myocardial hypertrophy - arteriosclerotic</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 18.)	20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from Feb 17 19 60, to Feb 17 19 60, that I last saw the deceased alive on Feb 17 19 60, and that death occurred at 12 25 M, from the causes and on the date stated above.

ACTUAL SIGNATURE <u>P. L. Tabb, M.D.</u> M.D. <u>13000 94. AVE</u>	ADDRESS (Street, city or town, state)	DATE SIGNED
PHYSICIAN'S NAME (Type) <u>S. L. TABB, M.D.</u>	<u>S. L. TABB, M.D.</u>	<u>S. L. TABB, M.D.</u>

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation</u>	22b. DATE THEREOF <u>2/18/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Augusta</u>	22d. LOCATION (City, town, or county) (State) <u>Georgia</u>
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23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>F. Gasch's Sons Hyattsville, Maryland.</u>	24a. REC'D BY REGISTRAR DATE <u>FEB 19 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MISSISSIPPI  
DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1918

NAME OF DECEASED  
AGE  
SEX  
RACE  
DATE OF BIRTH  
PLACE OF BIRTH  
OCCUPATION  
CAUSE OF DEATH  
PLACE OF DEATH  
DATE OF DEATH  
TIME OF DEATH  
SIGNATURE OF PHYSICIAN  
SIGNATURE OF REGISTRAR  
LOCAL HEALTH OFFICER

MISSISSIPPI DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
JANUARY 1, 1918

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

02210

2248

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>P.G.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN lb <b>12 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Edgvert</b> Last <b>METTS</b>				4. DATE OF DEATH Month <b>February</b> Day <b>29</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-27-07</b>		9. AGE (In years last birthday) <b>53</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Horace METTS</b>				14. MOTHER'S MAIDEN NAME <b>Hattie DONALDSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW II</b>		INFORMANT <b>(Wife) Marie U. METTS</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>332x</b> IMMEDIATE CAUSE (a) <b>Basilar Artery Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>17 February</b> , 19 <b>60</b> , to <b>29 February</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>29 February</b> , 19 <b>60</b> , and that death occurred at <b>10:05AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James M Brown</b>				ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>3-1-60</b>			
PHYSICIAN'S NAME (Type) <b>J.M. BROWN LT MC USN</b>				U.S. Naval Hospital, NNMC, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-3-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee 4th and Mass. Ave. N.W. Washington D.C.</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 2 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kenna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-100000

Subject: (Name)

12 days

East Pakistan

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

William

Robert

William

William

Male

White

2-10-51

23

U.S. Navy

U.S. Government

Georgia

U.S.

Robert James

Robert James

Y-2 (W 11)

(W 11) (W 11) (W 11) (W 11)



29 February

29 February

10:00 AM

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

Robert

Robert James

Robert James



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1b &amp; d Film G258 3/11/60 1wk

2249  
CERTIFICATE OF DEATH

Reg. Dist. No.

02211

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton Md.</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Wheaton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>her residence-13300 Georgia Avenue</b>		d. STREET ADDRESS <b>13300 Georgia Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Maud E Meyer</b>		4. DATE OF DEATH Month <b>February</b> Day <b>28</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 8, 1893</b>
9. AGE (In years last birthday) <b>66 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John W. Berkeley</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Allen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Dorothea E. Marek</b>		Address <b>13300 Ga. Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLISM, Left Lung.</b> <b>466X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Thrombus Left RIGHT ATRIUM</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/27</b> , 19 <b>60</b> , to <b>2/28</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>2/27</b> , 19 <b>60</b> , and that death occurred at <b>2:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>13018 Georgia Ave Silver Spring Md 2/28/60</b>			
ACTUAL SIGNATURE <b>AW Smith</b>		M.D. <b>13018 Georgia Ave Silver Spring Md</b>	
PHYSICIAN'S NAME (Type) <b>A.W. SMITH</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar 2, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Deal Funeral Home</b>		ADDRESS <b>4812 Ga. Ave N. W.</b>	
24a. REC'D BY REGISTRAR <b>MAR 7 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

0245

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Time of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar		11. Signature of informant		12. Signature of witness	
JAMES J. HENRY		M		45		1910		10:00 AM		New York City		Heart Disease		Natural		J. J. Henry		J. J. Henry		J. J. Henry		J. J. Henry	
13. Name of informant		14. Address of informant		15. Name of registrar		16. Address of registrar		17. Name of physician		18. Address of physician		19. Name of witness		20. Address of witness		21. Name of witness		22. Address of witness		23. Name of witness		24. Address of witness	
J. J. Henry		1234 5th Ave		J. J. Henry		1234 5th Ave		J. J. Henry		1234 5th Ave		J. J. Henry		1234 5th Ave		J. J. Henry		1234 5th Ave		J. J. Henry		1234 5th Ave	
25. Name of witness		26. Address of witness		27. Name of witness		28. Address of witness		29. Name of witness		30. Address of witness		31. Name of witness		32. Address of witness		33. Name of witness		34. Address of witness		35. Name of witness		36. Address of witness	
J. J. Henry		1234 5th Ave		J. J. Henry		1234 5th Ave		J. J. Henry		1234 5th Ave		J. J. Henry		1234 5th Ave		J. J. Henry		1234 5th Ave		J. J. Henry		1234 5th Ave	

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the Department of Health, at Albany, New York, this 10th day of January, 1910.

JOHN J. HENRY, Registrar

## 2250 CERTIFICATE OF DEATH

02212

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>33 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>2377 North Quincy Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Jane</b> Last <b>Montgomery</b>				4. DATE OF DEATH Month <b>February</b> Day <b>9</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 28, 1938</b>	
9. AGE (In years last birthday) <b>21</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Stephen Miles Montgomery</b>				14. MOTHER'S MAIDEN NAME <b>Annie G. Roberts</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastrointestinal hemorrhage</b> 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Acute lymphocytic leukemia</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>2 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>January 7, 1960</b> to <b>February 9, 1960</b> that I lost saw the deceased alive on <b>February 9, 1960</b> , and that death occurred at <b>6:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>2/10/60</b> ACTUAL SIGNATURE <b>Lawrence A. Gaydos</b> M.D. <b>The Clinical Center</b> PHYSICIAN'S NAME (Type) <b>LAWRENCE A. GAYDOS, M.D.</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>2/10/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Columbia Gardens</b>	
22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Thomas</b> ADDRESS <b>Arlington Funeral Home 3901 No. Fairfax Drive</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 15 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# STATE OF TEXAS

Washington

Virginia

Montgomery

Washington

22 days

Richmond

27th March 1918

The Clinical Center, Bethesda, Md.

2

February 2

Montgomery

James

Anna

21

March 28, 1918

White

James

U.S.A.

Washington, D.C.

Home

Student

James H. Johnson

Stephen H. Montgomery

The Medical Center

The Clinical Center, Bethesda, Md.

Home

No

2 weeks

Governmental Laboratory

2 weeks

Acute Infectious Diseases

February 2, 1918

January 7, 1918

February 2, 1918

The Clinical Center

National Institute of Health

Bethesda, Md.

LAWRENCE A. DAVIS, M.D.

March 28, 1918

March 28, 1918

March 28, 1918

Washington Clinical Center, 3001 R. R. Building, Bldg. 10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02213

2251 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Tennessee</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>316 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chattanooga</b> <b>79x-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>3714 St. Elmo Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Eugene</b> Middle <b>MONTGOMERY</b> Last <b>MONTGOMERY</b>				4. DATE OF DEATH Month <b>February</b> Day <b>13</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-6-39</b>		9. AGE (In years last birthday) <b>20</b> yrs.	IF UNDER 1 YEAR Months <b>2</b> Days <b>13</b> Hours <b>13</b> Min.	IF UNDER 24 HRS. Hours <b>13</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William MONTGOMERY</b>				14. MOTHER'S MAIDEN NAME <b>Leola BROOKS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>1957toDOD</b>		INFORMANT <b>Hospital Records</b>		Address	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>196.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>metastatic disease</b> DUE TO (c) <b>Osteosarcoma of left humerus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2 days</b> <b>7 months</b> <b>1 years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 3</b> , 1959, to <b>February 13</b> , 1960, that I last saw the deceased alive on <b>February 13</b> , 1960, and that death occurred at <b>8:50A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>2-13-60</b>							
ACTUAL SIGNATURE <b>N. T. Debevoise</b>		M.D. <b>U. S. Naval Hospital</b>					
PHYSICIAN'S NAME (Type) <b>N. T. DEBEVOISE, LT, MC, USN</b>		<b>Bethesda 14, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>		22b. DATE THEREOF <b>2-16-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Chattanooga National</b>		22d. LOCATION (City, town, or county) (State) <b>Chattanooga Tenn.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George D. Chambers</b> ADDRESS <b>W.W.Chambers Co., 1400 Chapin St,NW, WashDC</b>				24a. REC'D BY REGISTRAR <b>FEB 16 60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thayer</b>	

MEDICAL CERTIFICATION

UNITED STATES OF AMERICA

U. S. Navy Hospital  
37th St. 3rd Avenue  
Charleston, S. C.

U. S. Navy  
8-6-32

U. S. Navy  
Hospital  
Charleston, S. C.

U. S. Navy  
Hospital  
Charleston, S. C.

U. S. Navy  
Hospital  
Charleston, S. C.

U. S. Navy  
Hospital  
Charleston, S. C.

U. S. Navy  
Hospital  
Charleston, S. C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

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2252

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073  
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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02214

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 7 HR. 25 MIN.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL, INC. RT. #3 SHADY GROVE ROAD						d. STREET ADDRESS							
3. NAME OF DECEASED (Type or print) First JAMES		Middle FRANKLIN		Last MOORE		4. DATE OF DEATH Month FEBRUARY		Day 20		Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/30/97		9. AGE (In years lost birthday) 62 yrs.		IF UNDER 1 YEAR Months 10 Days 20		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OPERATING ENGINEER				10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. ret.		11. BIRTHPLACE (State or foreign country) VIRGINIA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME JAMES MOORE						14. MOTHER'S MAIDEN NAME TINA --- Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No WW1 1917-1918				16. SOCIAL SECURITY NO. Yes-Unknown		17. INFORMANT HOSPITAL RECORDS				Address OLNEY, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Nephrosis. DUE TO (c) Chronic myocarditis, Emphysema.												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 1958 to 2-19-60 that (I) (we) last saw the deceased alive on Feb 19 1960, and that death occurred at 12:50 A from the causes and on the date stated above.													
22a. SIGNATURE L. I. Leal M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE 2/19/60					
22c. PHYSICIAN'S NAME (Type) L. I. LEAL, M. D.						22d. ADDRESS GAITHERSBURG, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2/23/60		23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery				23d. LOCATION (City, town, or county) Gaithersburg, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey						ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE FEB 24 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

1 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, and in any event within 72 hours after death.

2123

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Mont.</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			c. LENGTH OF STAY IN 1b <b>56</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10219 Southmoor Drive</b>				d. STREET ADDRESS <b>10219 Southmoor Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>Henry</b> Last <b>Moreland</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>19</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 15, 1888</b>		9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired, Chief Finance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William S. Moreland</b>				14. MOTHER'S MAIDEN NAME <b>Susanna Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT <b>Mrs. Miriam M. Chester</b>		Address <b>daughter</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia (bacterial type)</b> <b>481X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Influenza</b> DUE TO (c) <b>AORTIC STENOSIS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b>  <b>2 WEEKS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>AORTIC STENOSIS</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>FEB 5, 1960</b> to <b>FEB 19, 1960</b> , that I last saw the deceased alive on <b>FEB 19, 1960</b> , and that death occurred at <b>7:35 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1821 QUEST, N.W. WASH. D.C.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Harry Zehner M.D.</b>		PHYSICIAN'S NAME (Type) <b>HARRY ZEHNER</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>2/22/60</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co., 2901 14th St. N.W.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 23 '60</b>		24b. REGISTRAR'S SIGNATURE <b>John S. Hines</b>	

MEDICAL CERTIFICATION

02214

CERTIFICATE OF DEATH

2123

Montgomery

Elmer E. Jones

Elmer E. Jones

10212 Southern Drive

10212 Southern Drive

19 19 60

Montgomery

Henry

Paul

Dec 11, 1964

Male

U.S.A.

Washington, D.C.

U.S.A.

Washington, D.C.

Thomas Brown

William E. Howard

Washington

Mr. William E. Howard

Washington, D.C.

1964

1964

Washington, D.C.

2/22/60

The B. E. Jones Co., 2001 N. 1st St., Wash. D.C.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02216

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b <u>5 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4406 Anthon Dr.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kensington</u> d. STREET ADDRESS <u>4406 Anthon Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Helen</u> Middle <u>B.</u> Last <u>Morris</u>			<b>4. DATE OF DEATH</b> Month <u>Feb</u> Day <u>12</u> Year <u>1960</u>								
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>							
<b>8. DATE OF BIRTH</b> <u>12-23-1887</u>		<b>9. AGE</b> (In years last birthday) <u>72</u> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-----</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>D.C.</u>							
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.C</u>											
<b>13. FATHER'S NAME</b> <u>Patrick Gleason</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Stinson</u>								
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Francis Donohue</u> Address <u>Ilw 2</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>483X Acute Congestive heart failure</u> DUE TO (b) <u>Influenza</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>5 days</u>						
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Port II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschert</u>			<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>								
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschert</u>			<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>								
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			<b>DATE SIGNED</b> <u>2-12-60</u>								
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>2/16/60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u>							
<b>22d. LOCATION (City, town, or county)</b> <u>Arlington, Virginia</u>											
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey</u>			<b>ADDRESS</b> <u>Bethesda, Maryland</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE FEB 16 '60</u>						
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>											

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





2124

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montg</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Liberty Springs Md</u>		c. LENGTH OF STAY IN lb <u>56</u> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2301 Douglas Court Lib Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Le Beau Rest Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ann Elizabeth</u> First Middle Last <u>Murray</u>		4. DATE OF DEATH Month <u>2</u> - Day <u>19</u> - Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-26-88</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Artist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp</u>	
11. BIRTHPLACE (State or foreign country) <u>M. J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Murray</u>		14. MOTHER'S MAIDEN NAME <u>Mary McAloney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cirrhosis Liver</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>58</u> , to <u>Feb 19</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 16</u> , 19 <u>60</u> , and that death occurred at <u>7:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert T. Thibodeau</u> M.D.		ADDRESS (Street, city or town, state) <u>10609 CINCINNATI ST REARINGTON, MD</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBODEAU</u>		DATE SIGNED <u>3/9/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2/22/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St John Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Montg Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W A Huntman &amp; Son</u>		ADDRESS <u>5732 Ka Ave</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Carling S. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

*[Faint, illegible handwriting throughout the form, likely bleed-through from the reverse side.]*

2175

CERTIFICATE OF DEATH

02218

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN lb <b>11 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Sanitarium</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>P.G.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>6220 - 58th Ave. 16-66-2</b> d. STREET ADDRESS <b>Forest Hgts, Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Nelle</b> Middle <b>Mae</b> Last <b>Murray</b>		4. DATE OF DEATH Month <b>February</b> Day <b>13</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 11, 1893</b>
9. AGE (In years lost birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>13</b> Hours <b>13</b> Min.	IF UNDER 24 HRS. Hours <b>13</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TELEPHONE OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TELEPHONE</b>	11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Edward Casson</b>	
14. MOTHER'S MAIDEN NAME <b>MARY WOOD</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>NONE</b>	
16. SOCIAL SECURITY NO. <b>INFORMANT</b>		17. ADDRESS <b>MRS. EDNA NAUGHTON 6116 W. CHESTER DR. CAMP SPRING, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1750</b> <b>Exsanguination</b> DUE TO <b>Esophageal Varices</b> <b>Portal Obstruction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Abdominal Carcinomatosis</b> DUE TO (c) <b>Ovarian Carcinoma, Primary</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 29, 1959</b> to <b>Feb 13, 1960</b> , that I last saw the deceased alive on <b>February 13, 1960</b> , and that death occurred at <b>6:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10609 Concor d Street</b> DATE SIGNED <b>Feb 13, 1960</b>			
ACTUAL SIGNATURE <b>Robert T. Thibadeau</b> M.D.		PHYSICIAN'S NAME (Type) <b>Robert T. Thibadeau, M.D. Kensington, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-16-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet</b>	22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home - Washington D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 16 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS  
COUNTY OF DALLAS

NOTARIAL PUBLIC

My Comm. Expires

11 Days

1900 - 1901

My Comm. Expires

101st

101st

101st

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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2253

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

02219

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>21 HR. 15 MIN.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL, INC.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MT. AIRY</b> d. STREET ADDRESS <b>RT. #3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>HARRISON BENJAMIN MYERS</b>				4. DATE OF DEATH Month Day Year <b>FEBRUARY 24 19 60</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/4/87</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES ALLEN MYERS</b>				14. MOTHER'S MAIDEN NAME <b>HENRIETTA FISHER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-03-0554</b>		17. INFORMANT <b>HOSPITAL RECORDS</b>		Address <b>OLNEY, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CARDIAC FAILURE</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <b>ARTERIOSCLOEROTIC HEART DISEASE</b> DUE TO (c) <b>5 YRS.</b> INTERVAL BETWEEN ONSET AND DEATH <b>36 HRS.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BRONCHOPNEUMONIA - 1 WK.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>FEB. 23</b> , 1960, to <b>FEB. 24</b> , 1960, that (I) (we) last saw the deceased alive on <b>FEB. 24</b> , 1960, and that death occurred <b>10:15A</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>C. S. Whitaker, M.D.</i> M.D.				22b. DATE SIGNED <b>FEB. 25, 1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>C. S. WHITAKER, M. D.</b>				22d. ADDRESS <b>CLARKSVILLE, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 27, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Simpson Methodist</b>		23d. LOCATION (City, town, or county) (State) <b>Poplar Springs, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Olin L. Moleworth</i> ADDRESS <b>Damascus, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 29 '60</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
STATE OF NEW YORK  
CERTIFICATE OF DEATH

1923

DECEASED

HARRISON

10-10-1923

10-10-1923

10-10-1923

DECEASED

HARRISON

10-10-1923

10-10-1923

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10-10-1923



2254  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>2125 Leewood Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Rebecca</u> Middle <u>A.</u> Last <u>Nebel</u>		4. DATE OF DEATH Month <u>2</u> Day <u>22</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/26/24 1923</u>
9. AGE (In years last birthday) <u>36</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ohio</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Wirpel</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Sanders</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
INFORMANT <u>Husband</u>		Address <u>as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compressive pulmonary atelectasis</u> <u>578 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <u>Serous effusion</u> DUE TO (c) <u>Immunization and hypoproteinemia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ulcerative colitis; Status postoperative resection proctocolon</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>unknown</u> <u>unknown</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>FEB 14</u> , 19 <u>60</u> , to <u>FEB 22</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>FEB 22</u> , 19 <u>60</u> , and that death occurred at <u>12:58 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Murphy</u>		ADDRESS (Street, city or town, state) <u>1801 EYE St NW Washington, D.C.</u>	
DATE SIGNED <u>  </u>		DATE SIGNED <u>  </u>	
PHYSICIAN'S NAME (Type) <u>Dr. John Murphy</u>		DATE SIGNED <u>  </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 26, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brown</u>	22d. LOCATION (City, town, or county) (State) <u>Colesburg, Iowa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Barry Mountcastle</u>		24a. REC'D BY REGISTRAR <u>Cunningham Funeral Home, Inc. Cameron and Alfred Sts. Alex. Va.</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Travis</u>		DATE <u>FEB 24 '60</u>	

1  
5  
X  
074  
1  
2  
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

Figure 2

# CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>35 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>2325 42nd Street N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Alan G. NICHOLS</b>		4. DATE OF DEATH Month Day Year <b>February 27 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-29-93</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>	
11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George NICHOLS</b>		14. MOTHER'S MAIDEN NAME <b>Frances GAITHER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>579-09-6653</b>	
17. INFORMANT <b>(Son) Eugene C. NICHOLS</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>23 January</b> , 19 <b>60</b> , to <b>27 February</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>27 February</b> , 19 <b>60</b> , and that death occurred at <b>10:00AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda Md. 2-29-60</b> ACTUAL SIGNATURE <b>James M. Young</b> PHYSICIAN'S NAME (Type) <b>J.M. YOUNG LT MC USN</b> <b>U.S. Naval Hospital, Bethesda Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-2-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gartner Gaithersburg, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 2 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>			

Division of Research

Washington, D.C.

Washington

32 days

Postman (Rental)

1955-1956 Survey

U.S. Naval Hospital, Bethesda, Md.

History

C.

1955

1-27-55

White

Male

Division of Research

Postman

Postman

Francis D. Lister

George H. Lister

275-02-025 (son) George C. Lister, born 1912

1912

27 January 1955

27 January

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

Washington, D.C.

Washington, D.C.

Washington, D.C.

## CERTIFICATE OF DEATH

Reg. Dist. No.

02222

2256

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <b>Florida</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Orlando</b> 48 X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>			d. STREET ADDRESS <b>1101 Nottingham Avenue</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>Minerva (None) Nirenberg</b>			4. DATE OF DEATH Month Day Year <b>February 15 1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 19, 1905</b>		9. AGE (In years last birthday) <b>54</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Samuel Bykowsky</b>			14. MOTHER'S MAIDEN NAME <b>Lena Raphaelson</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bacteremia with gram negative rods</b> DUE TO (b) <b>Right pyelonephritis</b> DUE TO (c) <b>Carcinoma of adrenal cortex with extensive metastasis 3 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>December 13, 1959</b> , to <b>February 15, 1960</b> , that I last saw the deceased alive on <b>February 15, 1960</b> , and that death occurred at <b>12:15 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center Bethesda 14, Maryland</b> DATE SIGNED <b>2-15-60</b> ACTUAL SIGNATURE <b>John L. Lewis, Jr.</b> PHYSICIAN'S NAME (Type) <b>John L. Lewis, Jr., M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>2/17/69</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	
22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>			
24a. REC'D BY REGISTRAR DATE <b>FEB 16 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Krasop</b>			

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

Florida

Florida

1101 North Main Avenue

Minors

(None)

February 12, 1950

New York

John H. H. H.

The Medical Record

The Clinical Center, Bethesda, Md., Maryland

Bacteremia with gram negative rods

Right pharyngitis

Examination of adrenal cortex with extensive metastasis 3 years

x

December 13, 1949

12:15A

The Clinical Center

National Institutes of Health

Bethesda, Md., Maryland

John I. Lewis, Jr., M.D.

Edward Hill Greenwood

Robert A. Johnson



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>2257</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>D. O. A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Ken sington</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>				d. STREET ADDRESS <b>3817 Decatur Ave;</b>			
3. NAME OF DECEASED (Type or print) First <b>Daisy</b> Middle <b>Nycinth</b> Last <b>Norris</b>				4. DATE OF DEATH Month <b>February</b> Day <b>14</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1900</b>	9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hwvf.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U:S.A.</b>	
13. FATHER'S NAME <b>Frank Crist</b>				14. MOTHER'S MAIDEN NAME <b>Lily B. Witt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Della Fram(daughter)930 Emerson, Wash; D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Brachial Asthma</b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>2 yr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschert</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. Broschert</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/18/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>Feb 16 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Carlton S. House</b>			

TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
2150 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Item 8 Film 6257 2-29-60 et										
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN town <b>YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>7137 Maple Ave</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> d. STREET ADDRESS <b>7137 Maple Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Axel A. Ostrom</b>					4. DATE OF DEATH <b>Feb. 23, 1960</b>					
5. SEX <b>male</b>					6. COLOR OR RACE <b>white</b>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>6/20/1887</b>					
9. AGE (In years last birthday) <b>72</b>					10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>					10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) <b>Finland</b>					12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Arvid Ostrom</b>					14. MOTHER'S MAIDEN NAME <b>Engman</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.					
17. INFORMANT <b>Greta S. Ostrom</b>					Address <b>Item 2</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>Frank J. Broschart</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DATE SIGNED <b>Feb. 23, 1960</b>										
Address (Street, city, town, or county)										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>FEB. 25, 1960</b>					
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>					22d. LOCATION (City, town, or county) (State) <b>Prince Georges County, Md.</b>					
23. FUNERAL DIRECTOR <b>Arthur S. Knaus</b>					ADDRESS <b>WASH DC 254 CARROLL ST. N.W.</b>					
24a. REC'D BY REGISTRAR <b>FEB 25 '60</b>					24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>					



## 2258 CERTIFICATE OF DEATH

02225

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>mont. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>57 Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>7613-Cayuga Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>M.</u> Last <u>Pachuta</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 4 1891</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Paul L. Mariniak</u>				14. MOTHER'S MAIDEN NAME <u>Anna Wellingford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Anna Pachuta - daughter</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHO PNEUMONIA</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>CEREBRAL THROMBOSIS AND HEMIPLEGIA, RT.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>1 MONTH</u> <u>4 MONTHS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>NOV. 1959</u> to <u>FEB. 14, 1960</u> that I last saw the deceased alive on <u>FEB. 14, 1960</u> and that death occurred at <u>7:35 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leo M. Curtis</u>				ADDRESS (Street, city or town, state) <u>8218 WISCONSIN AVE, BETHESDA, MD.</u>			
PHYSICIAN'S NAME (Type) <u>Leo M. Curtis</u>				DATE SIGNED <u>3/18/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/18/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Carmel, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58



STATE OF OHIO  
DEPARTMENT OF HEALTH

Form with multiple sections for recording health data, including fields for name, age, sex, date of birth, date of death, cause of death, and place of death. The form is divided into several horizontal sections with labels for each field.



TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02226
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>✓</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			47X-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Sanitarium &amp; Hosp</u>					d. STREET ADDRESS <u>737 Aspen St. N.W.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Grace Gladmon Pearce</u>					4. DATE OF DEATH Month <u>Feb</u> Day <u>13</u> Year <u>1960</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-3-1875</u>		9. AGE (In years last birthday) <u>84</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bureau of Vital Statistics (retired)</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Montgomery D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>		
13. FATHER'S NAME <u>Burgess K. Gladmon</u>					14. MOTHER'S MAIDEN NAME <u>Eliza E. Duling</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hosp record</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 902.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bones - pneumonia</u> (c) <u>Fracture left hip</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>3 days</u> <u>10 days</u>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell off chair to floor at home</u>					
20c. TIME OF INJURY Month, Day, Year <u>8:30 a.m.</u> <u>2-3-60</u> 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Washington</u> <u>DC</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2-13-60</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			22b. DATE THEREOF <u>2/16/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>S.H. Hines &amp; Co</u>					ADDRESS <u>2901-14th St. N.W.</u> <u>Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>FEB 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

STATE OF  
HEALTH DEPT.

MASSACHUSETTS DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: WILLIAM BROOK

2. SEX: MALE

3. AGE: 65

4. DATE OF DEATH: 1910

5. PLACE OF DEATH: AT HOME

6. OCCUPATION: RETIRED

7. CAUSE OF DEATH: HEART DISEASE

8. MANNER OF DEATH: NATURAL

9. SIGNATURE OF MEDICAL EXAMINER: [Signature]

10. SIGNATURE OF ATTENDING PHYSICIAN: [Signature]

11. SIGNATURE OF CORONER: [Signature]

12. SIGNATURE OF JURY: [Signature]

13. SIGNATURE OF DECEASED: [Signature]

14. SIGNATURE OF WITNESSES: [Signature]

15. SIGNATURE OF FUNERAL HOME: [Signature]

16. SIGNATURE OF BURIAL PLACE: [Signature]

17. SIGNATURE OF INTERVIEWER: [Signature]

18. SIGNATURE OF REPORTER: [Signature]

19. SIGNATURE OF CLERK: [Signature]

20. SIGNATURE OF OFFICIAL: [Signature]

CERTIFICATE OF DEATH

Reg. Dist. No.

02227

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2259		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>5 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BROOKEVILLE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL, INC. RT. #1 Box #159</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b>		Middle <b>ELLEN</b>		Last <b>PEARCE</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>1</b> Year <b>19 60</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/9/83</b>		9. AGE (In years last birthday) <b>77</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WESTLYN DAVIS</b>				14. MOTHER'S MAIDEN NAME <b>JOSEPHINE ROBERTS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>NONE</b>		INFORMANT <b>HOSPITAL RECORDS</b>		Address <b>OLNEY, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured heart</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Myocardial Infarction</b> DUE TO (c) <b>Coronary Thrombosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>6 days</b> <b>6 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/6</b> to <b>2/1</b> <b>1960</b> , that I last saw the deceased alive on <b>2/1</b> <b>1960</b> , and that death occurred at <b>4:10 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SANDY SPRING, MARYLAND</b> DATE SIGNED <b>2/1/60</b>							
ACTUAL SIGNATURE <b>C. H. LIGON</b>		M.D. <b>SANDY SPRING, MARYLAND</b>					
PHYSICIAN'S NAME (Type) <b>C. H. LIGON, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-3-60-</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Salem Meth. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Brookeville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis L. Barber Laytonville Md.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 4 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

3222

NO. 1000000

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

TIME

DECEASED AT THE HOME OF THE DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

TIME

DECEASED AT THE HOME OF THE DECEASED

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

DECEASED AT THE HOME OF THE DECEASED

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

## 2260 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>5415.2mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>V. T.</u> Last <u>Peters</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 28, 1917</u>
9. AGE (In years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>9</u> Hours <u></u> Min. <u></u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>John William Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Dare</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>- - - - -</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>T. Graham Peters</u>		Address <u>Bethesda, Md 4717 S. Chelseakia</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u> DUE TO <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1958</u> to <u>Feb 1, 1960</u> , that I last saw the deceased alive on <u>JAN 27, 1960</u> , and that death occurred at <u>5:35 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>DeWitt E. DeLauster</u>		ADDRESS (Street, city or town, state) <u>8025 ABERDEEN RD. Bethesda Md</u>	
DATE <u>2/1/60</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>DeWITT E. DeLauster, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-4-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Friends Meeting House</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>Carlton E. Kline</u>	
ADDRESS <u>Bethesda, Maryland</u>		DATE <u>FEB 4 '60</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4. may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0-528

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

2280

Blank certificate form with horizontal lines for text entry.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2b FilmG258 3-8-60 et

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

02229

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>2261</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>1 hour</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head Manor</b> <b>08X-2</b> d. STREET ADDRESS <b>22 Edgewood Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Roger</b> Middle <b>Gordon</b> Last <b>POCHUREK</b>		4. DATE OF DEATH Month <b>February</b> Day <b>29</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-7-60</b>
9. AGE (In years last birthday) yrs. <b>22</b>		IF UNDER 1 YEAR Months <b>22</b> Days <b>22</b> Hours <b>22</b> Min. <b>22</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Lawrence M. POCHUREK</b>		14. MOTHER'S MAIDEN NAME <b>Shirley J. KAPPEN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>(Father) Lawrence M. Pochurek</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>752X Apneic spell</b> DUE TO <b>Brain damage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hydroanencephaly</b> DUE TO (c) <b>Hydroanencephaly</b>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>4 wks</b> <b>4 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>29 February, 19 60</b> , to <b>29 February, 19 60</b> , that I last saw the deceased alive on <b>29 February, 19 60</b> , and that death occurred at <b>1:50P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED ACTUAL SIGNATURE <b>G.B. Avery</b> M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b> PHYSICIAN'S NAME (Type) <b>G.B. AVERY LT MC USN</b> <b>U.S. Naval Hospital, NNMC, Bethesda Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-3-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b> ADDRESS <b>7557 Wisconsin Ave. Bethesda Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 3 '60</b> DATE <b>2051314XUS</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles Chambers</b>			

# MINUTE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
2262  
CERTIFICATE OF DEATH

02230

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WASHINGTON, D. C.</b> b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>				c. LENGTH OF STAY IN 1b <b>5 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL, INC.</b>				d. STREET ADDRESS <b>6688 32ND PLACE, N. W.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>JESSE</b> Middle <b>ELLIS</b> Last <b>PORTER</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>24</b> Year <b>19 60</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/13/95</b>		9. AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Chief of Domestic Parts Corp. of Engineers-USGovt.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>WASHINGTON, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ELLIS PORTER</b>				14. MOTHER'S MAIDEN NAME <b>ANNIE SHERWOOD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W.W. I</b>		17. INFORMANT <b>HOSPITAL RECORDS</b>		Address <b>OLNEY, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>9 DAYS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>FEBRUARY 15 1960</b> , to <b>FEBRUARY 24 1960</b> , that (I) (we) last saw the deceased alive on <b>FEB. 23 19 60</b> , and that death occurred at <b>8:10AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <i>William C. Miller</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM C. MILLER, M. D.</b>				22d. ADDRESS <b>GALTHERSBURG, M.D.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/26/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co.-2901 14th St., N.W.</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 25 '60</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

CERTIFICATE OF DEATH

2262

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
COUNTY GENERAL REGISTRAR

NAME: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE: [illegible]  
DATE: [illegible]

## CERTIFICATE OF DEATH

Reg. Dist. No.

02231

2263

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Peru, South America</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>11 days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>			d. STREET ADDRESS <b>Arica 132</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Bella</b> Middle <b>Tuchia</b> Last <b>Prentice</b>			4. DATE OF DEATH Month <b>February</b> Day <b>25</b> Year <b>1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 11, 1953</b>		9. AGE (In years last birthday) yrs. <b>6</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None (Student)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Lima, Peru, So. America</b>		12. CITIZEN OF WHAT COUNTRY? <b>Peru, S. America</b>
13. FATHER'S NAME <b>Carlos Prentice</b>			14. MOTHER'S MAIDEN NAME <b>Bella Tuchia</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure, postoperative state</b> DUE TO <b>754.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Tetralogy of fallot</b> DUE TO (c) <b>6 yrs.</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 days</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>February 11, 1960</b> , to <b>February 25, 1960</b> , that I last saw the deceased alive on <b>February 25, 1960</b> , and that death occurred at <b>4:15 PM</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>[Signature]</i>		M.D. <b>The Clinical Center</b>		DATE SIGNED <b>2/26/60</b>	
PHYSICIAN'S NAME (Type) <b>E. KENT CARNEY, M. D.</b>		<b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>SHIP</b>		22b. DATE THEREOF <b>3-13-1960</b>		22c. NAME OF CEMETERY OR CREMATORY	
22d. LOCATION (City, town, or county) (State) <b>IGUITOS PERU SO AMERICA</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co</b>		ADDRESS <b>1400 Chapin St N.W.</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 1 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH

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## CERTIFICATE OF DEATH

Reg. Dist. No.

02232

2264

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>14 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital</b>				/d. STREET ADDRESS <b>Box 113</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Roy</b> Middle <b>Buearl</b> Last <b>Puckett</b>				4. DATE OF DEATH Month <b>February</b> Day <b>6</b> Year <b>19 60</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-6-1910</b>	
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months <b>49</b> Days <b>49</b> Hours <b>49</b> Min.		IF UNDER 24 HRS. Months <b>49</b> Days <b>49</b> Hours <b>49</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Montg. Co. Tree</b>		11. BIRTHPLACE (State or foreign country) <b>Div. Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Sam Joseph Puckett</b>				14. MOTHER'S MAIDEN NAME <b>Taves May Stevebsib</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW 11 230-14-2891</b>			
17. INFORMANT <b>Mildred B. Puckett</b>				Address <b>Box 113, Brookeville Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma Right Lung</b> DUE TO <b>162.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>with metastases to left lung, liver, lymph nodes, and vertebrae</b> DUE TO (c) <b>nodes, and vertebrae</b>							INTERVAL BETWEEN ONSET AND DEATH <b>six mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>October 18 59</b> to <b>Feb. 7 1960</b> , that I last saw the deceased alive on <b>February 6 19 60</b> , and that death occurred at <b>10:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles S. Whitaker, M.D.</b>				ADDRESS (Street, city or town, state) <b>Clarksville, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Charles S. Whitaker, M.D.</b>				DATE SIGNED <b>Feb 9 '60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/10/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler Funeral Home</b>				ADDRESS <b>1331 E. Montg. Rockville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

11503

CERTIFICATE OF DEATH

1. Name of deceased: Charles S. Whitaker, D.D.  
2. Date of death: October 12, 1907  
3. Place of death: Starkville, Maryland  
4. Age at death: 60  
5. Sex: Male  
6. Color: White  
7. Occupation: Editor of the Starkville Herald  
8. Cause of death: Heart disease  
9. Signature of physician: Dr. J. H. [illegible]  
10. Signature of registrar: [illegible]  
11. Date of registration: October 15, 1907  
12. Place of registration: Starkville, Maryland

## 2265 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery Co.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <b>Pr. Geo's Co.</b> MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Norbeck</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>District Heights</b> 16 23.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Philomema Nursing Home</b>		d. STREET ADDRESS <b>7609 - Gateway Blvd.</b>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>B.</b> Last <b>PUMPHREY</b>		4. DATE OF DEATH <b>Feb. 8th.</b> Month <b>Feb.</b> Day <b>8th.</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 24th 1890</b> 9. AGE (In years last birthday) <b>69</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Mollie Soper</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Mrs. Marian Ellis</b>		18. ADDRESS <b>7609--Gateway Blvd, District Heights, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>one week</b> <b>20 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 6, 1960</b> , to <b>February 8, 1960</b> , that I last saw the deceased alive on <b>Feb 8, 1960</b> , and that death occurred at <b>5:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>HARRY J. KICHERER</b> M.D.		ADDRESS (Street, city or town, state) <b>5527 Surrey St. Chevy Chase, Md.</b>	
DATE SIGNED <b>Feb. 8-1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-11-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, DC</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Bros</b>		24. REC'D BY REGISTRAR <b>FEB 10 1960</b>	
ADDRESS <b>1661--Good Hope Rd., SE Washington 20 DC</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

2265

Dr. Geo. W. Co.

Dr. Geo. W. Co.

Dr. Geo. W. Co.

Dr. Geo. W. Co.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

112234

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <span style="float: right;">2266</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6912 Barret Ave</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Verona</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Verona</b> <span style="float: right;">67X-3</span> d. STREET ADDRESS <b>87 Forest Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>AUGUSTA PURLSON</b> <span style="float: right;">First Middle Last</span>		4. DATE OF DEATH <b>Feb 21</b> <span style="float: right;">Month Day Year 19 60</span>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 12 1898</b> <span style="float: right;">9. AGE (In years last birthday) <b>62</b> yrs.</span>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Russia</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Abraham Cohen</b>		14. MOTHER'S MAIDEN NAME <b>Rose Soper</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Sanford Slavin</b> <span style="float: right;">Address <b>Ited Id</b> (Son In Law)</span>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. TIME OF INJURY Month, Day, Year <b>19</b> <span style="float: right;">20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></span>	
20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20e. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> <span style="float: right;">M.D.</span>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>2-21-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-23-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>KING DAVID MEMORIAL GARDEN - FALLS CHURCH. VA.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. DANZANSKY &amp; SONS - 3501-14 13th St. N.W.</b>		24a. REC'D BY REGISTRAR <b>FEB 24 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		24c. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the words "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2267

CERTIFICATE OF DEATH

Reg. Dist. No.

02235

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>57 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>New York</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New York City</b> d. STREET ADDRESS <b>505 West 161st Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Aristides</b> Last <b>Ramirez</b>		4. DATE OF DEATH Month <b>February</b> Day <b>16</b> Year <b>19 60</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 8, 1933</b>		9. AGE (In years last birthday) <b>26</b> yrs.		10. IF UNDER 1 YEAR Months <b>26</b> Days <b>26</b> Hours <b>26</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>				11. BIRTHPLACE (State or foreign country) <b>Puerto Rico</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Tomas Ramirez</b>						14. MOTHER'S MAIDEN NAME <b>Theresa Chapriel</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>126-24-1076</b>				INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Candida parapsilosis</b> DUE TO (c) <b>Endocarditis - aortic valve</b>												INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>  <b>11 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>December 21, 1959</b> , to <b>February 16, 1960</b> , that I last saw the deceased alive on <b>February 16, 1960</b> , and that death occurred at <b>6:44 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>February 17, 1960</b> ACTUAL SIGNATURE <b>Howard M. Kravetz</b> M.D. <b>The Clinical Center</b> PHYSICIAN'S NAME (Type) <b>HOWARD M. KRAVETZ, M.D.</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVED</b>				22b. DATE THEREOF <b>2/18/60</b>				22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State) <b>New York N.Y.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b> ADDRESS <b>Co. 1400 Chapin St. N.W. Wash. 9, D.C.</b>				24a. REC'D BY REGISTRAR <b>DATE FEB 19 '60</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>							

• The Clinical Center, Bethesda, Md.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

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FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02236

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <u>md</u> b. COUNTY <u>Monty</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton Silver Spring</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>56 Wheaton, Silver Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2620 Blue Ridge Ave</u>			d. STREET ADDRESS <u>1 2620 Blue Ridge Ave</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dorsey Lee Reynolds</u>			4. DATE OF DEATH Month Day Year <u>Feb 18 1960</u>		
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>6-24-1883</u>		9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>foreman - Monty Co. Highway Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Va</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.C.</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>JOSEPH Reynolds</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH THOMAS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-40-8022</u>		17. INFORMANT <u>Cornelia Reynolds (wife)</u> Address <u>Stun 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>sudden</u> (a), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
21. ACTUAL SIGNATURE <u>Frank J. Brosenart</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Brosenart</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>2-18-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/23/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>IVY HILL CEMETERY</u>	
22d. LOCATION (City, town, or country) (State) <u>ALEXANDRIA, VIRGINIA</u>					
23. FUNERAL DIRECTOR <u>WARNER E. PUMPHREY, INC.</u>		ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>FEB 23 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Raymond A. Ziska</u>					

100-21111  
100-21111

MASSACHUSETTS DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [Illegible]

2. SEX: [Illegible]

3. AGE: [Illegible]

4. DATE OF BIRTH: [Illegible]

5. PLACE OF BIRTH: [Illegible]

6. OCCUPATION: [Illegible]

7. CAUSE OF DEATH: [Illegible]

8. MANNER OF DEATH: [Illegible]

9. SIGNATURE OF EXAMINER: [Illegible]

10. DATE OF EXAMINATION: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2269

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

02237

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>11 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> 16X-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>4411 Beachwood Drive</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Annie Hartenstine RHOADS</b>				4. DATE OF DEATH Month Day Year <b>February 10 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-17-76</b>	
9. AGE (In years lost birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>Henry HARTENSTINE</b>				14. MOTHER'S MAIDEN NAME <b>Hanna FRYER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>(S) Robt. H. Rhoads, same as #2 above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, stomach with metastasis</b> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 30</b> , 19 <b>60</b> , to <b>February 10</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>February 10</b> , 19 <b>60</b> and that death occurred at <b>10:50 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital 2-11-60</b> ACTUAL SIGNATURE M.D. <b>J. L. BEEBY, LT, MC, USN Bethesda 14, Maryland</b> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>		22b. DATE THEREOF <b>2-11-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Forest Hills</b>		22d. LOCATION (City, town, or county) (State) <b>Reiffton Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Funeral Home, Hyattsville, Md.</b>				24a. REC'D BY REGISTRAR <b>FEB 15 60</b>		24b. REGISTRAR'S SIGNATURE <b>Conrad S. Throckmorton</b>	

# CERTIFICATE OF DEATH

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## 2270 CERTIFICATE OF DEATH

Reg. Dist. No.

02258  
215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>VIRGINIA</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN lb <b>7 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>U.S. NAVAL HOSPITAL NMMC</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b> <b>83 X-3</b>	
f. NAME OF DECEASED (Type or print) <b>Audrey</b> <b>First</b> <b>Weston</b> <b>Middle</b> <b>RICH</b> <b>Last</b>		g. DATE OF DEATH <b>February</b> <b>6</b> <b>Day</b> <b>19</b> <b>60</b> <b>Year</b>	
h. SEX <b>Female</b>	i. COLOR OR RACE <b>White</b>	j. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	k. DATE OF BIRTH <b>5-13-83</b>
l. AGE (In years last birthday) <b>76</b> yrs.		m. IF UNDER 1 YEAR Months Days Hours Min.	
n. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		o. KIND OF BUSINESS OR INDUSTRY - - - - -	
p. BIRTHPLACE (State or foreign country) <b>MASS.</b>		q. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
r. FATHER'S NAME <b>George RHINES</b>		s. MOTHER'S MAIDEN NAME <b>Effie RHINES</b>	
t. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		u. SOCIAL SECURITY NO. <b>021-05-7486</b>	
v. INFORMANT <b>Elinor D. RICH(D)</b>		w. Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Arteriosclerosis</b> DUE TO lying cause (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>31 January 1960</b> to <b>6 February 1960</b> , that I last saw the deceased alive on <b>6 February 1960</b> , and that death occurred at <b>2015 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S.N.H., NMMC, Bethesda 2660</b> DATE SIGNED ACTUAL SIGNATURE <b>Marshall W. Olson</b> M.D. PHYSICIAN'S NAME (Type) <b>M.W. OLSON</b> <b>LCDR MC USN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11 Feb. 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Plain Street Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Braintree, Mass.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wheatley Funeral Home</b>		24a. REC'D BY REGISTRAR <b>FEB 9 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

1 The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

2270

VIRGINIA

Alexander

1 day

Death (Date)

302 North Carolina Dr. Va

U.S. NAVY HOSPITAL

Rich

Weston

Admiral

1902

1902

White

Female

1902

1902

White

Female

SHIRAZ

1902

1902

White

Female

021-02-1902 (1902) 1902

(Date of death)

(Date of death)

(Date of death)

(Date of death)

(Date of death)

(Date of death)

(Date of death)

(Date of death)

(Date of death)

(Date of death)

(Date of death)

1  
 TO DEPUTY MEDICAL EXAMINER: If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Item 20 Film 280 3-10-60 ams										MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02239														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.																								
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>					b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>					c. LENGTH OF STAY IN 1b <b>D.O.A.</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>					d. STREET ADDRESS <b>1331 Rittenhouse St. N.W.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Chesman</b> Last <b>Ricketts</b>										4. DATE OF DEATH Month <b>February</b> Day <b>19</b> Year <b>1960</b>																								
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 18, 1910</b>				9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months <b>47</b> Days <b>x-3</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>																				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dishwasher</b>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <b>British W. Indies</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>																			
13. FATHER'S NAME <b>John Ricketts</b>										14. MOTHER'S MAIDEN NAME <b>Lillian Jeffries</b>																								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.					17. INFORMANT <b>Estelle Gonzales (Neife)</b>					Address <b>RA3-2541</b>																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>936.5</b> DUE TO <b>Aspiration of Gastric Contents</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Aspiration of Gastric Contents</b> (b) <b>Aspiration of Gastric Contents</b> (c) <b>Aspiration of Gastric Contents</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Aspiration</b>																								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was driving his car &amp; stopped to repair his tire chains when he suddenly collapsed</b>																													
20c. TIME OF INJURY Month, Day, Year <b>1:20 a.m. 2-19 1960</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>					20f. (City or town) (County) (State) <b>Bethesda Montg. Md.</b>																			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <b>Natural Causes</b> <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .																																		
ACTUAL SIGNATURE <b>Frank J. Bloschant</b> M.D.										CHIEF MEDICAL EXAMINER <input type="checkbox"/>																								
EXAMINER'S NAME (Type) <b>FRANK J. Bloschant</b>										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																								
										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>2.24.60</b>					22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>					22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>																			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert G. McGuire</b>										ADDRESS <b>1820 9th St., N.W. Washington, D.C.</b>					24a. REC'D BY REGISTRAR <b>DATE FEB 23 '60</b>					24b. REGISTRAR'S SIGNATURE <b>Clara E. Hume</b>														



## 2272 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <del>Frederick</del> <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>101 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Poolesville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>1 - - - - -</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Lawrence</b> Last <b>RIHELDAFFER</b>				4. DATE OF DEATH Month <b>February</b> Day <b>6</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-24-89</b>	9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Naval Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John C. RIHELDAFFER</b>				14. MOTHER'S MAIDEN NAME <b>Laura HARDEN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WWI - WWII</b>		INFORMANT Address <b>(W) Evelyn D. Riheldaffer, same as #2 above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, bronchogenic</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive cardiovascular disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>7 mo</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 28, 1959</b> to <b>February 6, 1960</b> , that I last saw the deceased alive on <b>February 6, 1960</b> , and that death occurred at <b>8:15P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>F. J. Linehan</b>		M.D. <b>U. S. Naval Hospital</b>		DATE SIGNED <b>2-7-60</b>			
PHYSICIAN'S NAME (Type) <b>F. J. LINEHAN, JR., LCDR, MC, USN Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>2-9-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Maryland</b>	
22e. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey Funeral Home, Bethesda, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 9 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Himes</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

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## APPENDIX



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2125

## CERTIFICATE OF DEATH

Reg. Dist. No.

02241

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>6 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>12,715 Flack St.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b> d. STREET ADDRESS <b>12,715 Flack Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>GRANT</b> Last <b>ROBERTS</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>14</b> Year <b>19 60</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/27/04</b>
9. AGE (In years lost birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>14</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dance Instructor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>	
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>NATHEN ROSENBERG</b>		14. MOTHER'S MAIDEN NAME <b>? SULLIVAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>172-24-2415</b>	
17. INFORMANT Address <b>Mrs. Catherine W. Roberts, 12,715 Flack St.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Arteriosclerosis 5 years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Myocardial Infarction 1 day</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Essential Hypertension</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	
20c. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>Feb 1</b> , 19 <b>58</b> , to <b>Feb 14</b> , 19 <b>60</b> that I last saw the deceased alive on <b>Feb 14</b> , 19 <b>60</b> , and that death occurred at <b>5 A</b> M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>John J. Curry</b> M.D.		ADDRESS (Street, city or town, state) <b>10620 Georgia Ave Silver Spring, Md</b>	
PHYSICIAN'S NAME (Type) <b>JOHN J. CURRY</b>		DATE SIGNED <b>2/14/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/17/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PIMPHREY, INC.</b> <b>Raymond A. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>FEB 16 60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>36 Hrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Barbara</b> Middle <b>Ellen</b> Last <b>Robinson</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>5</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/13/77</b>	9. AGE (In years last birthday) <b>82 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>Jackson, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>JOHN Henry Strope</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE CAROLINE Fox</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		INFORMANT <b>Maurice Robinson (Husband)</b> Address <b>Same as Above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332x Cerebral Vascular Thrombosis</b> DUE TO (b) <b>Arteriosclerosis Cerebral-Cardiovascular Disease</b> DUE TO (c) <b>Arteriosclerosis Cerebral-Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus Compensated &amp; Acidosis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>2-3</b> , 1960, to <b>2-5</b> , 1960, that I last saw the deceased alive on <b>2-5</b> , 1960, and that death occurred at <b>4:45</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>P. P. Andrews</b>		ADDRESS (Street, city or town, state) <b>4201 Rescension St NW-560 Washington D.C.</b>					
PHYSICIAN'S NAME (Type) <b>Peter P. Andrews</b>		DATE SIGNED <b>Feb 8 '60</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>		22b. DATE THEREOF <b>2/8/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>UNION CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>COLUMBUS, OHIO</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 8 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Clifton S. Frank</b>			

1. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

FILE NO.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2152

## CERTIFICATE OF DEATH

02243

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>MONTG.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MILDRED JEANNETTE ROSE</u>		4. DATE OF DEATH Month Day Year <u>FEB 14 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-30-1901</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>INDIANA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HURLIE R. LONTZ</u>		14. MOTHER'S MAIDEN NAME <u>EFFIE FENIMORE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Address			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>153.8</u> DUE TO <u>Abdominal Viscera secondary to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Primary Carcinoma of Colon</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>3 1/2 yrs</u>
---	--	---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		

21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>57</u> , to <u>Feb 14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 13</u> , 19 <u>60</u> , and that death occurred at <u>1:35</u> P. M., from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>George L. Ball</u>	DATE SIGNED <u>FEB 14 1960</u>
PHYSICIAN'S NAME (Type) <u>George L. Ball</u>	ADDRESS (Street, city or town, state) <u>10620 Georgia Ave Silver Spring Md</u>

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Feb 1960</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Belmont National Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Belmont Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>		24a. REC'D BY REGISTRAR <u>2540 CAMPBELL ST NW</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>
		DATE <u>FEB 17 '60</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02244

Reg. Dist. No.

2274

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban</b>			d. STREET ADDRESS <b>9705 De Paul Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Christopher</b> Middle <b>A.</b> Last <b>Ross</b>			4. DATE OF DEATH Month <b>Feb</b> Day <b>19</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-11-1960</b>		9. AGE (In years last birthday) <b>7</b> yrs. <b>9</b> Months <b>1</b> Days <b>8</b> Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>---</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.C.</b>					
13. FATHER'S NAME <b>William David Ross</b>			14. MOTHER'S MAIDEN NAME <b>Patricia June Bagley</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Suburban Hosp. Record</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.5 Congestive heart failure</b> DUE TO (b) <b>Subaortic stenosis</b> DUE TO (c) <b>Congenital heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>---</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Frank J. Brosehart</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>FRANK J. BROSEHART</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>2/23/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	
22d. LOCATION (City, town, or county) <b>Suitland, Maryland</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>			ADDRESS <b>Bethesda Maryland</b>		
24a. REC'D BY REGISTRAR <b>FEB 24 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			

TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2074315XUS

100

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>District of Columbia</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>16 da.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium Hospital</i>		d. STREET ADDRESS <i>415 - 19th St. N.W.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Fannie Otto Rupert</i>		4. DATE OF DEATH Month Day Year <i>Feb 23 1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-8-70</i>
9. AGE (In years last birthday) <i>89</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired - War Dept.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
11. BIRTHPLACE (State or foreign country) <i>Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Rupert, Wm.</i>		14. MOTHER'S MAIDEN NAME <i>Martin, Elizabeth</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>-</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>-</i>		Address <i>-</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Glomerular Nephritis</i> <i>592x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Mural Thrombosis aorta</i> DUE TO (c) <i>-</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>-</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i> <i>1 wk.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2-9-</i> , 19 <i>60</i> , to <i>2-23</i> , 19 <i>60</i> , that I lost saw the deceased alive on <i>2-23</i> , 19 <i>60</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert A. Hare</i>		ADDRESS (Street, city or town, state) <i>809 Davis Ave., T. Park, Md.</i> DATE SIGNED <i>2/23/60</i>	
PHYSICIAN'S NAME (Type) <i>Robert A. Hare M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>2-26-1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>	22d. LOCATION (City, town, or county) (State) <i>Suitland, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jas. Sawle</i>		24a. REC'D BY REGISTRAR <i>1756 Pa. Ave. N.W.</i> DATE <i>FEB 25 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

212

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of death: *Jan 15 1892*

5. Place of death: *Home*

6. Cause of death: *Heart Disease*

7. Signature of physician: *Dr. J. Smith*

8. Signature of registrar: *John Doe*

9. Date of registration: *Jan 16 1892*

10. Place of registration: *New York City*

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2275

CERTIFICATE OF DEATH

Reg. Dist. No.

02246

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>88 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover</b> d. STREET ADDRESS <b>100 3rd Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Clyde (None) Russell</b>				4. DATE OF DEATH Month Day Year <b>February 19 19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 14, 1914</b>	
9. AGE (In years last birthday) <b>45</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Staff Sergeant</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John M. Russell</b>				14. MOTHER'S MAIDEN NAME <b>Hattie Wiseman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>(Active duty) Unascertainable</b>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial Obstruction</b> <b>190.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Malignant Melanoma</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 Hour</b> <b>8 Years</b>				18. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 23, 1959</b> to <b>February 19, 1960</b> , that I last saw the deceased alive on <b>February 19, 1960</b> , and that death occurred at <b>10:00am</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>2-19-60</b> ACTUAL SIGNATURE <b>Charles E. Mengel</b> M.D. PHYSICIAN'S NAME (Type) <b>CHARLES E. MENGEL, M.D.</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/23/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. J. Rinaldi</b>				ADDRESS <b>Rinaldi Funeral Home, Inc.</b> <b>816 H St., NE, Wash., DC</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 23 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NAME	DATE OF BIRTH	DATE OF DEATH	PLACE OF BIRTH	PLACE OF DEATH	CAUSE OF DEATH	DIAGNOSIS	TESTS
John H. Russell	U.S.A.	July 14, 1958	West Virginia	U.S.A.	Heart Disease	Myocardial Infarction	Active duty (unascertainable)
Staff Sergeant							
Male							
Clyde							
(None)							
Russell							
February 19							
100 3rd Street							
Bedford							
88 days							
Landover							
Maryland							
Prince Georges							

1. Name: John H. Russell  
2. Date of Birth: U.S.A.  
3. Date of Death: July 14, 1958  
4. Place of Birth: West Virginia  
5. Place of Death: U.S.A.  
6. Cause of Death: Heart Disease  
7. Diagnosis: Myocardial Infarction  
8. Tests: Active duty (unascertainable)

February 19 60  
November 25 59  
February 19 60  
10:00 AM  
The Clinical Center  
National Institute of Health  
Bethesda, Maryland  
2-19-60



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2276 CERTIFICATE OF DEATH

Reg. Dist. No.

02247

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <b>Montgomery</b> <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boyd's--Rural</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boyd's----Rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Osie</b> Middle <b>Bertha</b> Last <b>Savage</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>1</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 13-1891</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles Poole</b>		14. MOTHER'S MAIDEN NAME <b>Rachel V. House</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mr Leroy Savage, Boyds, R.D.D, Maryland</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Hemorrhage</b> DUE TO (c) <b>Cerebral arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>6 days</b> <b>2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 3</b> , 19 <b>59</b> , to <b>Feb 1</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Feb 1</b> , 19 <b>60</b> , and that death occurred at <b>5:00 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Beallsville, Maryland</b> DATE SIGNED <b>Feb 2-60</b> ACTUAL SIGNATURE <b>Vernon E. Martens</b> M.D. PHYSICIAN'S NAME (Type) <b>Vernon E. Martens</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/3/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>	22d. LOCATION (City, town, or county) (State) <b>Beallsville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William B. Hilton, Beallsville, MD</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 4 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 2154 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>50 min-</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>				d. STREET ADDRESS <u>4865-66th Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>Joseph</u> Last <u>SCHANA</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>28</u> Year <u>60</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/13/80</u>	
9. AGE (In years lost birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Austria</u>				12. CITIZEN OF WHAT COUNTRY? <u>American</u>			
13. FATHER'S NAME <u>? Duchon</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN-</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>SON-JENNINGS W SCHANA</u>				Address <u>4865-66th Ave Hyattsville Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>(same)</u> DUE TO (c) <u>(same)</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Medical anticoagulation (Dicumeral)</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Oct.</u> , 19 <u>59</u> to <u>2/29/60</u> , that I last saw the deceased alive on <u>Feb. 6</u> , 19 <u>60</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Donald Nelson</u> M.D. <u>10620 Georgia Ave Silver Spring, Md</u>				DATE SIGNED <u>2/29/60</u>			
PHYSICIAN'S NAME (Type) <u>DONALD NELSON</u>				22a. DATE OF REMOVAL (Specify) <u>3-4-60</u>			
22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>			
22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u> ADDRESS <u>4812 Ga Ave NW</u>			
24a. REGISTERED BY REGISTRAR <u>MAR 1 1960</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

State of New York

County of ...

City of ...

Decedent

Age

Sex

Married

Occupation

Residence

Signature

Witness

Physician

Date

Time

Place

Signature

Witness

Physician

Signature

Witness

Physician

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Witness

Physician

Items 3.5 Film G256 2-19-60 et  
2277

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47 X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. NAVAL HOSPITAL NNMC</u>		d. STREET ADDRESS <u>2712 30th St. SE Apt. B 364</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Grover Cleveland SCHNELL</u>		4. DATE OF DEATH Month Day Year <u>February 7 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-1-85</u>
9. AGE (In years last birthday) yrs. <u>74</u>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Buchanan PADGETT</u>		14. MOTHER'S MAIDEN NAME <u>Arabelle LOCKARD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. INFORMANT Address <u>Mildred SLAUGHTER (D) same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6 February 1960</u> , to <u>7 February 1960</u> , that I last saw the deceased alive on <u>7 February</u> , 19 <u>60</u> , and that death occurred at <u>0115aM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Marshall W. Olson</u> M.D. <u>U.S. NH, NNMC Bethesda MD 2-7-60</u> PHYSICIAN'S NAME (Type) <u>M.W. OLSON LCDR MC USN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-11-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>She S. Hines</u> S.H. HINES		ADDRESS <u>2901 14th St. W.D.C.</u>	24a. REC'D BY REGISTRAR DATE <u>FEB 9 '60</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





2126

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN lb <b>3 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Marilea Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>G.</b> Last <b>SCHULER</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>16</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/1/68</b>
9. AGE (In years last birthday) <b>42</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor, Civilian employee of Marie Corps</b>		12. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
13. FATHER'S NAME <b>GODFREY SCHULER</b>		14. MOTHER'S MAIDEN NAME <b>MARY unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. Elwood W. Schuler, Dodge House, 20 E St. NW Washington, D.C.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>15 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 10, 1948</b> to <b>Feb 16, 1960</b> that I last saw the deceased alive on <b>Feb 16, 1960</b> and that death occurred at <b>5 P M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>9500 Colesville Rd Silver Spring Md</b> DATE SIGNED			
ACTUAL SIGNATURE <b>H.B. OKLEANS</b> M.D.		PHYSICIAN'S NAME (Type) <b>H.B. OKLEANS</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/19/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		22d. LOCATION (City, town, county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 18 '60</b>	
24b. REGISTRAR'S SIGNATURE <i>Anthony S. Hanna</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]

2. Sex: [illegible]

3. Age: [illegible]

4. Date of birth: [illegible]

5. Place of birth: [illegible]

6. Date of death: [illegible]

7. Cause of death: [illegible]

8. Signature of physician: [illegible]

9. Signature of registrar: [illegible]

10. Date of registration: [illegible]

11. Place of registration: [illegible]

12. Signature of informant: [illegible]

13. Date of information: [illegible]

14. Signature of informant: [illegible]

15. Date of information: [illegible]

16. Signature of informant: [illegible]

17. Date of information: [illegible]

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**2155 CERTIFICATE OF DEATH**

02251

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>10 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2001 CARROLL AVENUE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>B</u> Last <u>Secor</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18, 1912</u>	9. AGE (In years lost birth day) <u>47</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post Office</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa -</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Harry Secor</u>				14. MOTHER'S MAIDEN NAME <u>Emily Marie Wells</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1946</u>		17. INFORMANT <u>CLARA M. SECOR</u> Address <u>2001 CARROLL AVE. TAKOMA PARK, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Acc.</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Chr. Deg. Myocarditis -</u> DUE TO (c) <u>Arterial Pains - in</u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>  <u>2/2/60.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u></u> Day <u></u> Year <u>19</u> Hour <u></u> a. m. <u></u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>4/31</u> 19 <u>60</u> , to <u>2/18</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>2/14</u> 19 <u>60</u> , and that death occurred at <u>4:30</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Howard I Mouse</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Howard I Mouse</u>				22d. ADDRESS <u>2030 Carroll Ave. Takoma Park - 12 Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 23 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>	23d. LOCATION (City, town, or county) (State) <u>Washington Virginia</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Stalder</u> ADDRESS <u>254 CARROLL ST. NW. WASH. D.C.</u>				25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>		
				DATE <u>FEB 23 1960</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02821

U.S. DEPARTMENT OF HEALTH  
BUREAU OF VETERINARY MEDICINE  
WASHINGTON, D. C.  
2152  
CERTIFICATE OF DEATH

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

**1**  
**FOR STATE**  
**HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**2166 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

252

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>			
c. LENGTH OF STAY IN 1b <b>1 1/2 hrs.</b>				d. STREET ADDRESS <b>103 Dawson Ave., Apt. 134</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>20 Summit Ct.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Simmie John Shifflett</b>				4. DATE OF DEATH <b>Feb. 27, 1960</b> 19 <b>19</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/16/1923-1898</b> <b>52 62</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Mack Shifflett</b>				14. MOTHER'S MAIDEN NAME <b>Fannie Shifflett</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give war or dates of service)</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Mamie A. Shifflett. Rockville. Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>Feb. 27, 1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-1-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Park Lawn</b>		22d. LOCATION (City, town, or country) (State) <b>Rockville. Md.</b>	
23. FUNERAL DIRECTOR <b>Ernest C. Gartner. Gaithersburg. Md.</b>				24a. REC'D BY REGISTRAR <b>MAR 1 '60</b>			
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

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2182 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK

IN SENATE

January 1, 1900

REPORT OF THE

COMMISSIONER OF HEALTH

FOR THE YEAR 1899

ALBANY:

ANDREW D. DUNN, PRINTER

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02253

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakema Park D.O.C.</u> c. LENGTH OF STAY IN 1b <u>1670.2</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>099 Washington Sanitarium Hospital</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u> d. STREET ADDRESS <u>9223 Baltimore Blvd.</u>													
<b>3. NAME OF DECEASED</b> (Type or print) First <u>John</u> Middle <u>Andrew</u> Last <u>Sievert</u>		<b>4. DATE OF DEATH</b> Month <u>2</u> - Day <u>19</u> Year <u>1960</u>													
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>4-6-1932</u>												
<b>9. AGE</b> (In years last birthday) <u>27</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.					<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.													
Months	Days	Hours	Min.												
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Employment of Mrs. M.S. Gov.</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>md.</u>													
<b>11. BIRTHPLACE</b> (State or foreign country) <u>md.</u>		<b>13. FATHER'S NAME</b> <u>Louis E. Sievert</u>													
<b>14. MOTHER'S MAIDEN NAME</b> <u>Christina Gerstner</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>													
<b>16. SOCIAL SECURITY NO.</b> <u>?</u>		<b>17. INFORMANT</b> <u>Brother-in-law</u> Address <u>Beltsville md.</u> <u>David J. Breewood 4511 Yates Rd.</u>													
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>825x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>fracture of skull</u> (c) <u>fracture of skull</u> (a), stating the underlying cause lost.															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>													
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of car involved in accident</u>		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>12:30</u> a. m. <u>2-19</u> 19 <u>60</u>													
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>													
<b>20f. (City or town)</b> <u>Adelphi P.D.</u>		<b>(County)</b> <u>md.</u>													
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschant</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>													
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. BROSCANT</u>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>													
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <u>2-19-60</u>													
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>2/22/60</u>													
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Ft. Lincoln</u>		<b>22d. LOCATION (City, town, or county)</b> <u>Colmar Manor, Md.</u>													
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>E. Boschi Sons</u>		<b>24a. REC'D BY REGISTRAR</b> <u>FEB 24 '60</u>													
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hanes</u>		<b>24c. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hanes</u>													

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEATH NO. <b>1000</b> COUNTY <b>BALTIMORE</b>		DATE OF DEATH <b>10-15-1910</b> TIME OF DEATH <b>10:00 AM</b>	
NAME OF DECEASED <b>JOHN J. SMITH</b> SEX <b>M</b> AGE <b>45</b>		OCCUPATION <b>LABORER</b> PLACE OF BIRTH <b>IRELAND</b>	
MARITAL STATUS <b>MARRIED</b> NUMBER OF SURVIVORS <b>2</b>		CAUSE OF DEATH <b>HEART DISEASE</b> MANNER OF DEATH <b>NATURAL</b>	
SIGNATURE OF EXAMINER <b>J. J. SMITH</b> TITLE <b>PHYSICIAN</b>		SIGNATURE OF WITNESSES <b>J. J. SMITH</b> TITLE <b>PHYSICIAN</b>	
SIGNATURE OF CORONER <b>J. J. SMITH</b> TITLE <b>CORONER</b>		SIGNATURE OF JURY <b>J. J. SMITH</b> TITLE <b>JURY</b>	
SIGNATURE OF DECEASED <b>J. J. SMITH</b> TITLE <b>DECEASED</b>		SIGNATURE OF NEXT OF KIN <b>J. J. SMITH</b> TITLE <b>NEXT OF KIN</b>	
SIGNATURE OF BURIAL SOCIETY <b>J. J. SMITH</b> TITLE <b>BURIAL SOCIETY</b>		SIGNATURE OF FUNERAL HOME <b>J. J. SMITH</b> TITLE <b>FUNERAL HOME</b>	
SIGNATURE OF CHURCH <b>J. J. SMITH</b> TITLE <b>CHURCH</b>		SIGNATURE OF CEMETERY <b>J. J. SMITH</b> TITLE <b>CEMETERY</b>	
SIGNATURE OF MINISTERS <b>J. J. SMITH</b> TITLE <b>MINISTERS</b>		SIGNATURE OF OTHERS <b>J. J. SMITH</b> TITLE <b>OTHERS</b>	
SIGNATURE OF DECEASED <b>J. J. SMITH</b> TITLE <b>DECEASED</b>		SIGNATURE OF NEXT OF KIN <b>J. J. SMITH</b> TITLE <b>NEXT OF KIN</b>	
SIGNATURE OF BURIAL SOCIETY <b>J. J. SMITH</b> TITLE <b>BURIAL SOCIETY</b>		SIGNATURE OF FUNERAL HOME <b>J. J. SMITH</b> TITLE <b>FUNERAL HOME</b>	
SIGNATURE OF CHURCH <b>J. J. SMITH</b> TITLE <b>CHURCH</b>		SIGNATURE OF CEMETERY <b>J. J. SMITH</b> TITLE <b>CEMETERY</b>	
SIGNATURE OF MINISTERS <b>J. J. SMITH</b> TITLE <b>MINISTERS</b>		SIGNATURE OF OTHERS <b>J. J. SMITH</b> TITLE <b>OTHERS</b>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02254

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>099 Washington Sanitarium + Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u> d. STREET ADDRESS <u>1670-2 9223 Baltimore Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Veneta</u> Middle <u>(NKK)</u> Last <u>Sievert</u>				<b>4. DATE OF DEATH</b> Month <u>2</u> Day <u>-</u> Year <u>1960</u>													
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>11-28-28</u>		<b>9. AGE</b> (In years last birthday) <u>31</u> yrs. <table border="1" style="display: inline-table; width: 100%;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Inspector - Stone Straw. Co.</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Lynch Kentucky</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>U.S.G.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.G.</u>									
<b>13. FATHER'S NAME</b> <u>Stanley Hozalski</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Lacie ?</u>													
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>214-28-9595</u>		<b>17. INFORMANT</b> <u>Sister Mrs. Ann Breerwood - 4511 Bates Rd.</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="2"> <b>PART I. DEATH WAS CAUSED BY:</b>            IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage + laceration</u>            825X DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>fracture of skull</u>            DUE TO (c)         </td> <td> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>Sudden</u> </td> </tr> </table>								<b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage + laceration</u> 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>fracture of skull</u> DUE TO (c)		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Sudden</u>							
<b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage + laceration</u> 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>fracture of skull</u> DUE TO (c)		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Sudden</u>															
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>																	
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>War passenger in car involved in accident</u>													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>12:30</u> p. m. <u>2-19</u> 19 <u>60</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		<b>20f. (City or town)</b> <u>Adelphi</u>		<b>(County)</b> <u>P. G.</u>		<b>(State)</b> <u>MD</u>							
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
<b>ACTUAL SIGNATURE</b> <u>Frank J. Brosch</u> M.D.					<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>												
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Brosch 267</u>					<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>												
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					<b>DATE SIGNED</b> <u>2-19-60</u>												
<b>22a. BURIAL, CREMATION, or REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>2/22/60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Ft. Lincoln</u>			<b>22d. LOCATION</b> (City, town, or county) (State) <u>Colmar Manor, Md.</u>										
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. Jascha Sons</u> <u>4739 Baltimore Ave. Hyattsville, Md.</u>					<b>24a. REC'D BY REGISTRAR</b> <u>FEB 24 '60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kraus</u>										

TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## 2278 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> 83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Belmont Sanatorium</u>		d. STREET ADDRESS <u>2109-16 St. N.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Crain</u> Middle <u>Simpson</u> Last		4. DATE OF DEATH <u>Feb. 6</u> 19 <u>60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 April 1887</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>9</u> Days <u>9</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman Ret'd</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Delaware</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry P. Simpson</u>		14. MOTHER'S MAIDEN NAME <u>Anna Shepherd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Walter R. Simpson-Bethesda, Md.-Nephew</u>		3610 East West Hwy. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Myocardial Infarction</u> DUE TO (c) <u>arteriosclerotic Heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>30 minutes</u> <u>12 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify, that I attended the deceased from <u>Jan. 15</u> , 19 <u>46</u> , to <u>2/6</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb. 5</u> , 19 <u>60</u> , and that death occurred at <u>8:15</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Marcel J. Foret, M.D.</u>		ADDRESS (Street, city or town, state) <u>1746 K St NW</u>	
PHYSICIAN'S NAME (Type) <u>MARCEL J. FORET</u>		DATE SIGNED <u>Washington 6-11-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-8-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hollywood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Richmond, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>FEB 9 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur J. P...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







2127

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8103 Eastern Avenue</u>		d. STREET ADDRESS <u>8103 Eastern Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>Sipkin</u> Last <u>Sipkin</u>		4. DATE OF DEATH Month <u>February</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18, 1909</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Schwartz</u>		14. MOTHER'S MAIDEN NAME <u>Anna Rubin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>George Sipkin</u>	
17. INFORMANT <u>George Sipkin</u>		Address <u>8103 Eastern Ave., S.S., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED METASTATIC CARCINOMA</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA OF BREAST (POST-OP.)</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u> <u>OVER 6 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CORONARY ARTERIOSCLEROTIC HEART DISEASE</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>SEPTEMBER 19, 1958</u> , to <u>FEB. 22</u> , 1960, that I last saw the deceased alive on <u>FEB. 22</u> , 1960, and that death occurred at <u>11:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>2-23-60</u>			
ACTUAL SIGNATURE <u>Israel Kessler</u>		M.D. <u>5801-16 St., N.W., Wash., D.C.</u>	
PHYSICIAN'S NAME (Type) <u>ISRAEL KESSLER, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-24-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>King David Memorial Garden</u>	22d. LOCATION (City, town, or county) (State) <u>Falls Church, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky &amp; Sons</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 25 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2279

## CERTIFICATE OF DEATH

02257

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>47X-3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>926 Massachusetts Avenue, N.W.</b>			
3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>Thomas</b> Last <b>Smith</b>				4. DATE OF DEATH Month <b>February</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 17, 1903</b>	
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min.		IF UNDER 24 HRS. Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Robert L. Smith</b>				14. MOTHER'S MAIDEN NAME <b>Marilla Allen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>196-24-0071</b>			
17. INFORMANT <b>The Medical Record</b>				Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia, empyema, broncho-esophago-pleural fistula; pericarditis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Epidermoid carcinoma posterior mediastinum</b> DUE TO (c) <b>Epidermoid carcinoma mouth - no local recurrence</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>8 months</b> <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>December 9, 1959</b> , to <b>February 3, 1960</b> , that I last saw the deceased alive on <b>February 3, 1960</b> , and that death occurred at <b>7:50 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Seymour C. Nash</b>				ADDRESS (Street, city or town, state) <b>The Clinical Center</b>			
PHYSICIAN'S NAME (Type) <b>Seymour C. Nash, M.D.</b>				DATE SIGNED <b>2-4-60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>				22b. DATE THEREOF <b>Feb. 5, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Leo Crematory</b>	
22d. LOCATION (City, town, or county) <b>Washington D. C.</b>				22e. (State) <b>D. C.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. W. Wash. D. C.</b>				24a. REC'D BY REGISTRAR <b>FEB 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Conrad S. Thru</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1958 CERTIFICATE OF CLAIM

Director of Quarantine

Washington

The Clinical Center, Bethesda, Md.

Quarantine Division

Smith

March 17, 1958

White

Male

Director of Quarantine

Smith

White

Robert L. Smith

Family Room

The Clinical Center

156-21-0075 The Clinical Center, Bethesda, Md.

156-21-0075 The Clinical Center, Bethesda, Md.

156-21-0075 The Clinical Center, Bethesda, Md.

156-21-0075 The Clinical Center, Bethesda, Md.

Therapeutic

February 2, 1958

February 2, 1958

The Clinical Center  
National Institutes of Health  
Bethesda, Md.

Dr. Robert L. Smith, M.D.

2280

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>				c. LENGTH OF STAY IN 1b <b>7 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FRANCES</b> Middle <b>NEWMAN</b> Last <b>SMITH</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>2</b> Year <b>19 60</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/8/89</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <b>70</b> yrs.	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>GEORGE NEWMAN</b>				14. MOTHER'S MAIDEN NAME <b>HARRIETT HALL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>				16. SOCIAL SECURITY NO. <b>INFORMANT</b>			
17. ADDRESS <b>HOSPITAL RECORDS</b>				18. ADDRESS <b>OLNEY, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> DUE TO <b>Carcinoma of uterus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Bilateral Bronchopneumonia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <b>1/8</b> , to <b>2/2</b> , 19 <b>60</b> that I last saw the deceased alive on <b>2/2</b> , 19 <b>60</b> , and that death occurred at <b>11:05A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SANDY SPRING, MARYLAND</b> DATE SIGNED <b>2/2/60</b> ACTUAL SIGNATURE <b>C. H. LOGAN, M. D.</b> PHYSICIAN'S NAME (Type) <b>SANDY SPRING, MARYLAND</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>2/7/60</b> 22b. DATE THEREOF <b>2/7/60</b> 22c. NAME OF CEMETERY OR CREMATORY <b>2/7/60</b> 22d. LOCATION (City, town, or county) (State) <b>2/7/60</b> 23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b> ADDRESS <b>Rockville, Md.</b> 24a. REC'D BY REGISTRAR <b>FEB 10 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Haines</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

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STATE OF NEW YORK  
CERTIFICATE OF DEATH

DECEASED: MONTGOMERY, HARRY

AGE: 7 DAYS

PLACE OF DEATH: MONTGOMERY COUNTY GENERAL HOSPITAL

DATE OF DEATH: FEBRUARY 3, 1960

CAUSE OF DEATH: NECROSIS

PLACE OF BIRTH: HAWAII

DECEASED'S SIGNATURE

HOSPITAL RECORDS

*Handwritten notes:*  
The deceased was born on 1/27/60 at Honolulu, Hawaii.  
He was a male infant, born at 11:00 AM.  
He was the first child of Mr. and Mrs. Harry Montgomery.  
He was born at the Honolulu General Hospital.  
He was born at 11:00 AM on 1/27/60.  
He was born at the Honolulu General Hospital.  
He was born at 11:00 AM on 1/27/60.  
He was born at the Honolulu General Hospital.

DECEASED'S SIGNATURE: HARRY MONTGOMERY

*Handwritten signature*

DO NOT WRITE IN THESE SPACES



## 2281 CERTIFICATE OF DEATH

Reg. Dist. No.

02259

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>11 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hosp. Inc.</b>				d. STREET ADDRESS <b>Rt. 1</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Lillie Belle Smith</b>		First Middle Last		4. DATE OF DEATH <b>February 2 19 60</b>		Month Day Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/25/1901</b>	
9. AGE (In years lost birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Greenwood</b>				14. MOTHER'S MAIDEN NAME <b>Mary Susan Winters</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		INFORMANT <b>Hospital Recorded</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease with 420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>congestive failure</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Thyroid adenoma, chronic secondary anemia, chronic bronchitis</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 24 1960</b> to <b>Feb 2 1960</b> , that I last saw the deceased alive on <b>Feb 2 1960</b> , and that death occurred at <b>6:25 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G. F. Meadors</b>				ADDRESS (Street, city or town, state) <b>MAIN ST. DAMASCUS, MD.</b>			
PHYSICIAN'S NAME (Type) <b>G. F. MEADORS, M.D.</b>				DATE SIGNED <b>2/2/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/5/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>WINTERS CEM</b>		22d. LOCATION (City, town, or county) (State) <b>CARROLL COUNTY MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>D. D. Hartzler &amp; Sons</b>				ADDRESS <b>New Windsor Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 5 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

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VS A15 (4)  
ISM 9/58

STATE OF TEXAS  
COUNTY OF DALLAS

1922

Myself

Myself

Myself

Myself

Myself

Myself

Myself

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Myself

Myself

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>8 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>5907 Lone Oak Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Louise</b> Middle <b>C</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>February</b> Day <b>8</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 23, 1896</b>
9. AGE (In years last birthday) <b>64</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H swf.</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Buxton, Maine</b>	
13. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. FATHER'S NAME <b>Mark Rounds</b>		16. MOTHER'S MAIDEN NAME <b>Fannie Palmer</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		18. SOCIAL SECURITY NO. <b>yes</b>	
19. INFORMANT <b>Mrs Hattie Stone</b>		Address <b>above (daughter)</b>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b> 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Myocardial hypertrophy and dilatation</b> DUE TO (c) <b>Rheumatic Mitral &amp; Tricuspid Valvulitis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>years</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Patent Foramen Ovale</b>			9. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1/31, 1960</b> , to <b>2/8, 1960</b> , that I last saw the deceased alive on <b>2/7, 1960</b> , and that death occurred at <b>8:30 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles J. Savarese, M.D.</b>		ADDRESS (Street, city or town, state) <b>4890 BATTERY LA</b>	
PHYSICIAN'S NAME (Type) <b>CHARLES J. SAVARESE, M.D.</b>		DATE SIGNED <b>2/8/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	22b. DATE THEREOF <b>2/10/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Pine Grove Cmn</b>	22d. LOCATION (City, town, or county) (State) <b>Bethesda, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chry Chase Funeral Home</b>		24a. REC'D BY REGISTRAR <b>Wash. D.C.</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

No. 101

Age 45

Sex Male

Date of Birth 1907

Place of Birth

Jan 23, 1907

Married

Spouse's Name

Place of Death

Place of Death

Sex Male

Place of Birth

Age 45

Date of Birth 1907

Sex Male

No. 101

2283

Item 2 Film G258 3-7-60 et

## CERTIFICATE OF DEATH

02261

Reg. Dist. No.

## 1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

o. STATE

b. COUNTY

Maryland

Montgomery D.C.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Germantown

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Washington

47X-3

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Marylander Home

d. STREET ADDRESS

Cathedral Apts.  
Mr. Caithersburg, Marylande. IS RESIDENCE ON A FARM?  
YES ☐ NO ☒3. NAME OF DECEASED  
(Type or print)First  
NELLIE

Middle

Last  
SMITH

## 4. DATE OF DEATH

Month  
February 26

Day

Year  
19 60

## 5. SEX

F.

## 6. COLOR OR RACE

W

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

## 8. DATE OF BIRTH

NOV. 26, 1877

## 9. AGE (In years last birthday)

82 yrs.

## IF UNDER 1 YEAR

Months

Days

Hours

Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Govt. Retired

## 10b. KIND OF BUSINESS OR INDUSTRY

## 11. BIRTHPLACE (State or foreign country)

Pennsylvania

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

BARTRAM NAUSS

## 14. MOTHER'S MAIDEN NAME

MARGARET YINGER

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of service)

NO

## 16. SOCIAL SECURITY NO.

-

## INFORMANT

Address

N.Y.C.  
MRS. SARGENT (DAUGHTER) 220 E. 73 ST.

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

DUE TO

Cardiac Failure

## INTERVAL BETWEEN ONSET AND DEATH

5 days

Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.

DUE TO

Arteriosclerosis / Heart disease

years

Arteriosclerosis, generalized

years

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Senile dementia

## 19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour o. m.  
p. m.

19

## 20d. INJURY OCCURRED

While at work ☐ Not while at work ☐

## 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

## 20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Feb. 1955, to Feb 25, 1960, that I last saw the deceased alive on Feb 21, 1960, and that death occurred at 3:15 PM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

## ACTUAL SIGNATURE

Frederic D. Chapman

M.D.

1150 Conn Ave, Wash. D.C.

## PHYSICIAN'S NAME (Type)

FREDERIC D. CHAPMAN

1150 CONN. AVE. N.W. WASH. D.C.

## 22a. BURIAL, CREMATION, OR DISPOSAL (Specify)

CREM.

## 22b. DATE THEREOF

2-29-60

## 22c. NAME OF CEMETERY OR CREMATORY

CEDAR HILL

## 22d. LOCATION (City, town, or county)

SUITLAND,

(State)

MD.

## 23. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

Washington, DC

## 24a. REC'D BY REGISTRAR

DATE MAR 1 '60

## 24b. REGISTRAR'S SIGNATURE

Arthur S. Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2283 DEATH

Montgomery

Gettysburg

February 28

1862

1862

1862

1862

1862

1862

1862

1862

1862

1862

1862

1862

1862



## 2158 CERTIFICATE OF DEATH

02262

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>109 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Wesley Dow Smith</u>		4. DATE OF DEATH <u>Feb 14 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18, 1904</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Staff - Natl. Rifle Assoc</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rifle Clubs</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>William Smith</u>		14. MOTHER'S MAIDEN NAME <u>Mrs Clara Clodfelter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>364-14-6549</u>	
17. INFORMANT <u>Mrs Ruth Smith</u>		Address <u>10308-Colesville Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial infarction - Acute</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 14, 1960</u> to <u>Feb 14, 1960</u> , that I last saw the deceased alive on <u>Feb 14, 1960</u> , and that death occurred at <u>10:55 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilford D. Meyers</u>		ADDRESS (Street, city or town, state) <u>8323 Haddon Dr. Tak. Pk., Md.</u> DATE SIGNED <u>2/14/60</u>	
PHYSICIAN'S NAME (Type) <u>Wilford D. Meyers M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>2/16/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u>		24a. REC'D BY REGISTRAR <u>FEB 17 '60</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2159

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>17 TAKOMA PARK</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>514 DOMER AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>R</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>FEB</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/10/87</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONTRACTOR (Builder)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>	11. BIRTHPLACE (State or foreign country) <b>SOUTH CAROLINE</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>ROBERT SMITH</b>	
14. MOTHER'S MAIDEN NAME <b>LUCY MOSS</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>578-14-9088</b>		17. INFORMANT <b>Mr. Charles R. Smith, 1121 Caddington Ave. Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GENERALIZED ARTERIOSCLEROSIS</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CARCINOMA OF THE LUNG.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>MARCH</b> , 1958, to <b>FEB. 13</b> , 1960, that I last saw the deceased alive on <b>FEB. 12</b> , 1960, and that death occurred at <b>12:50 PM</b> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>ABRAHAM W. DANISH, M.D.</b>		ADDRESS (Street, city or town, state) <b>927 PERSHANS DR SILVER SPRING, MD.</b>	
DATE <b>2-14-60</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS &amp; BURIAL 2/16/60</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>GRACELAND CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>GREENVILLE, SOUTH CAROLINA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC. SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>FEB 16 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>		24c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1158

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED: [illegible]

AGE: [illegible]

SEX: [illegible]

RACE: [illegible]

DATE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

Cause of Death: [illegible]

Signature of Physician: [illegible]

Signature of Registrar: [illegible]

DATE: [illegible]

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02264

2128

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b — — —		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Latonsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>944 BONIFANT STREET</b>			d. STREET ADDRESS <b>Goshen School Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Charles WILLIAM Fenton SNOUFFER</b>			4. DATE OF DEATH Month <b>FEB.</b> Day <b>24</b> Year <b>1960</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 13, 1906</b>		9. AGE (In years last birthday) <b>53</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cycle Shop</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Charles Snouffer</b>			14. MOTHER'S MAIDEN NAME <b>Lucy Brady</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>577-05-6026</b>		17. INFORMANT <b>Mrs. Josephine Snouffer, Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Latonsville</b>	(County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Francis J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>2/24/60</b>	
EXAMINER'S NAME (Type) <b>FRANK J. BROSCHART</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/27/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		22d. LOCATION (City, town, or county) (State) <b>Montgomery, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>		ADDRESS <b>Latonsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 29 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>

TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02265

2284

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg R-2</u>		c. LENGTH OF STAY IN 1b <u>4 mo</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Derwood - R-1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pleasant View Nursing Home</u>			d. STREET ADDRESS <u>mt Zion</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Phoebe Waters Snowden</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>1</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>ere</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-14-1866</u>		9. AGE (In years last birthday) <u>93</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Nursing Home</u> Address <u>Stem-1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>1 day</u> (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u> DUE TO (c) <u>1 day</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>Feb 1 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>2/2/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>McGuire Funeral Home.,</u>	
				22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Rookville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 5 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

2



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2285

## CERTIFICATE OF DEATH

Reg. Dist. No.

02266  
215

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>6 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Clara</b> Middle <b>Alberta</b> Last <b>SNYDER</b>				4. DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-7-80</b>	
9. AGE (In years lost birthday) <b>79 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>			
13. FATHER'S NAME <b>David Myers</b>				14. MOTHER'S MAIDEN NAME <b>Alberta James</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>- - - - -</b>			
17. INFORMANT <b>Hospital Records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural hematoma, multiple</b> 33/x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>-</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 27</b> , 19 <b>60</b> , to <b>February 2</b> , 1960, that I last saw the deceased alive on <b>February 2</b> , 19 <b>60</b> , and that death occurred at <b>2:55 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>R. G. Galbraith Jr.</b> M.D. <b>U. S. Naval Hospital</b> <b>2-3-60</b>							
ACTUAL SIGNATURE <b>R. G. GALBRAITH, LT, MC, USN</b>				PHYSICIAN'S NAME (Type) <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment 2-4-60</b>		22b. DATE THEREOF <b>2-4-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Whitemarsh Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey Funeral Home, Bethesda, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 4 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

62-5-S      LEBIGSON LOREN .S .U

2286

## CERTIFICATE OF DEATH

Reg. Dist. No.

02267

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Benjamin</b> Last <b>Sosnik</b>				4. DATE OF DEATH Month <b>February</b> Day <b>27</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 14, 1943</b>	
9. AGE (In years last birthday) <b>16</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Harry Sosnik</b>				14. MOTHER'S MAIDEN NAME <b>Sophia Feldmann</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>			
INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> 421.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Hypertension</b> DUE TO (c) <b>Pulmonary Vascular Obstruction</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b> <b>6 months</b> <b>Over 6 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>February 24, 19 60</b> to <b>February 27, 19 60</b> that I last saw the deceased alive on <b>February 27, 19 60</b> and that death occurred at <b>10:15 PM</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Samuel M. Fox</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>2/28/60</b>			
PHYSICIAN'S NAME (Type) <b>Samuel M. Fox, M.D.</b>				National Institutes of Health <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>FEB. 29, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BETH SHOLOM CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>HILLSIDE Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B Danzanyak</b> ADDRESS <b>3501-145th. N.W.</b>				24a. REC'D BY REGISTRAR <b>MAR 1 '60</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Pina</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BP

VS A15 (4)  
15M 9/58

REPORT OF THE BOARD OF HEALTH

Division of Health

Washington

1918-1919

ST

1918-1919

1918-1919

U.S.A.

New York

1918-1919

1918-1919

1918-1919

1918-1919

1918-1919

1918-1919

1918-1919

1918-1919

1918-1919

1918-1919

1918-1919

1918-1919

1918-1919

1918-1919



2129

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>Since 1929</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9505 WOODLEY AVE.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b> d. STREET ADDRESS <b>1 9505 WOODLEY AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EDWARD ROBINSON STABLER</b> First Middle Last				4. DATE OF DEATH <b>FEBRUARY 15 19 60</b> Month Day Year			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/16/57</b>		9. AGE (In years last birthday) <b>102</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pharmacist (retired)</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>ROBINSON STABLER</b>			
14. MOTHER'S MAIDEN NAME <b>MARY HARTSHORNE</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>NONE</b>				17. INFORMANT Address <b>Mr. E. Kenneth Stabler, 9505 Woodley Ave. Forest Glen, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary insufficiency &amp; occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>coronary arteriosclerosis</b> DUE TO (c) <b>indefinite</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>secondary effects of advanced age (age 102)</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>no injury</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>1/25/60</b> , 19__, to <b>2/15/60</b> , 19__, that I last saw the deceased alive on <b>2/15/60</b> , 19__, and that death occurred at <b>9:20 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>E. L. Marston</b> M.D.				ADDRESS (Street, city or town, state) <b>800 Pershing Drive Silver Spring, Md.</b>			
DATE SIGNED <b>2/16/60</b>							
PHYSICIAN'S NAME (Type) <b>E. L. Marston</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2/18/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>WOODSIDE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BRINKLOW, MARYLAND</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC. Raymond A. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>FEB 18 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

218

DECEASED		DATE OF DEATH	
NAME		AGE	
SEX		RACE	
EDUCATION		OCCUPATION	
MARRIAGE		RELIGION	
BIRTH		DEATH	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF BIRTH		DATE OF DEATH	
TIME OF BIRTH		TIME OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		DATE	
PLACE		PLACE	
COUNTY		COUNTY	
STATE		STATE	
CITY		CITY	
ZIP CODE		ZIP CODE	
HOSPITAL		HOSPITAL	
PHYSICIAN		PHYSICIAN	
NURSE		NURSE	
CHAPLAIN		CHAPLAIN	
COUNSELOR		COUNSELOR	
CLERGYMAN		CLERGYMAN	
MINISTER		MINISTER	
PASTOR		PASTOR	
PRIEST		PRIEST	
RABBI		RABBI	
IMAM		IMAM	
SACERDOTE		SACERDOTE	
BISHOP		BISHOP	
ARCHBISHOP		ARCHBISHOP	
CARDINAL		CARDINAL	
POPE		POPE	
OTHER		OTHER	

2287

## CERTIFICATE OF DEATH

Reg. Dist. No.

02269

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>				MARYLAND c. LENGTH OF STAY IN 1b <b>9 DAYS</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLARKSBURG</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL</b>								d. STREET ADDRESS							
3. NAME OF DECEASED (Type or print) First Middle Last <b>SHERRI DARLENE STEVENSON</b>				4. DATE OF DEATH Month Day Year <b>FEBRUARY 10 1960</b>											
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/1/60</b>		9. AGE (In years lost birthday) yrs. <b>9</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>JAMES JUNIOR STEVENSON</b>								14. MOTHER'S MAIDEN NAME <b>LIZA JANE WRIGHT</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>NONE</b>				INFORMANT <b>HOSPITAL RECORDS</b>				Address <b>OLNDY, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity and Immaturity</b> <b>763.5</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bilateral Bronchopneumonia</b> (c) <b>DUE TO</b>												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>2/1</b> , 19 <b>60</b> , to <b>2/10</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>2/10</b> , 19 <b>60</b> , and that death occurred at <b>6:40 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SANDY SPRING, MARYLAND</b> DATE SIGNED <b>2/11/60</b>															
ACTUAL SIGNATURE <i>[Signature]</i>				M.D.											
PHYSICIAN'S NAME (Type) <b>C. H. LIGON, M. D.</b>				<b>SANDY SPRING, MARYLAND</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>2-12-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Days Creek</b>				22d. LOCATION (City, town, or county) (State) <b>Barnesville Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. B. Hilton</b>						ADDRESS <b>Barnesville Md</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 15 '60</b>		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

298

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ARMED DENTISTRY

ARMED DENTISTRY

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
2288 **CERTIFICATE OF DEATH**

02270

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>2½ months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Congressional Manor Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LILLY</b> Middle <b>C.</b> Last <b>STONE</b>				4. DATE OF DEATH Month <b>February</b> Day <b>8,</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 20, 1861</b>	
9. AGE (In years last birthday) yrs. <b>98</b>		IF UNDER 1 YEAR Months <b>5</b> Days <b>18</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Part Owner</b>				10b. KIND OF BUSINESS <b>Quarries</b>			
11. BIRTHPLACE (State or foreign country) <b>Stoneyhurst Stone Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John D. W. Moore</b>				14. MOTHER'S MAIDEN NAME <b>Sara B. Coltman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-32-5527</b>		17. INFORMANT <b>J. Dunbar Stone- Item #2 - Son</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO <b>Broncho pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b></b> (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>February 5, 1960</b> to <b>Feb. 8, 1960</b> , that (I) (we) lost saw the deceased alive on <b>Feb. 7, 1960</b> , and that death occurred <b>4:35 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert G. Angle</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE <b>2/8/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert G. Angle</b>				22d. ADDRESS <b>5009 Del Ray Ave., Bethesda, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-10-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR <b>FEB 9 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

06326338



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

2178

Items 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

02271

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Washington, D. C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3000 McComas Ave. Kensington Gardens Sanit.</b>		e. IS RESIDENCE ON A FARM? <b>YES</b> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ernest</b> Middle <b>B</b> Last <b>Swingle</b>		4. DATE OF DEATH Month <b>Feb</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/27/1878</b> 1868
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Roy L. Cobb-1300 Iris St. N.W.</b>		Address <b>Washington, DC</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TERMINAL PULMONARY EDEMA</b> DUE TO <b>Cerebral Accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-sclerosis</b> DUE TO (c) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 1/2 mos</b> <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>12/8/1939</b> to <b>2/13/1960</b> , that (I) (we) lost saw the deceased alive on <b>2/13/1960</b> , and that death occurred on <b>2/13/1960</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Francis X Richardson</b>		22b. ADDRESS <b>11412 Viers Mill Rd. Wheaton Md.</b>	
22c. PHYSICIAN'S NAME (Type) <b>Francis X Richardson</b>		22d. ADDRESS <b>11412 Viers Mill Rd. Wheaton Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/16/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Company</b>		25a. REC'D BY REGISTRAR <b>FEB 16 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

03271

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

2176

Date of Death		Place of Birth		Place of Death	
May 1, 1900		Boston, Mass.		Boston, Mass.	
Age		Sex		Race	
35		Male		White	
Married		Single		Occupation	
Yes		No		None	
Cause of Death		Disease		Duration	
Heart Disease		Myocardial Infarction		24 hours	
Immediate Cause		Underlying Cause		Contributing Cause	
Coronary Thrombosis		Atherosclerosis		Hypertension	
Symptoms		Diagnosis		Treatment	
Chest pain, shortness of breath		Physical examination, ECG		Aspirin, morphine	
Time of Death		Place of Death		Signature of Physician	
May 1, 1900, 10:30 AM		Boston, Mass.		J. H. Jones, M.D.	
Signature of Registrar		Signature of Coroner		Signature of Medical Examiner	
A. B. Smith		C. D. Jones		E. F. Green	

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02272

2283

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville R-2</u>		c. LENGTH OF STAY IN 1b <u>22 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville R-2</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Seven Locke Rd</u>			d. STREET ADDRESS <u>Seven Locke Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Emily Ann Thomas</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>6</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-2-1894</u>		9. AGE (in years last birthday) <u>66 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cafeteria</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.C.</u>	
13. FATHER'S NAME <u>Richard Miles</u>			14. MOTHER'S MAIDEN NAME <u>Rosa Lee Jones</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>421.4</u>		17. INFORMANT <u>Jeanette Baker - Sister</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Chronic Valvular Heart disease</u> DUE TO (c) <u>2 yrs</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rockville, Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Brosch</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/10/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park.</u>	
				22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Surdick</u>			ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 15 '60</u>
					24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

DATE OF BIRTH  
PLACE OF BIRTH

DATE OF  
DEATH

DATE OF  
DEATH

PLACE OF  
DEATH

CAUSE OF  
DEATH

SEX

AGE

WEIGHT

HEIGHT

TEMPERATURE

PULSE

BLOOD PRESSURE

RESPIRATIONS

DIAPHRAGM

STOMACH

INTESTINES

BLADDER

RECTUM

UTERUS

VAGINA

TESTES

PROSTATE

SPLEEN

LIVER

PANCREAS

GALLBLADDER

ESOPHAGUS

STOMACH

INTESTINES

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GALLBLADDER

ESOPHAGUS

STOMACH

INTESTINES

BLADDER

RECTUM

UTERUS

VAGINA

TESTES

PROSTATE

2290

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>4-4 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Maryland Thompson</u>		4. DATE OF DEATH Month <u>2</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 30, 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>James Andrew Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Emily Fox</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>578-20-9573</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>430.0</u> DUE TO <u>congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial hypertrophy &amp; dilation</u> (c) <u>arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>unknown</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/20/60</u> , 19 <u>60</u> , to <u>2/22/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/21/60</u> , 19 <u>60</u> , and that death occurred at <u>4:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward S. Witowski, Jr.</u>		ADDRESS (Street, city or town, state) <u>Suite 400, 8218 Wisconsin Ave.</u> DATE SIGNED <u>2/23/60</u>	
PHYSICIAN'S NAME (Type) <u>Edward S. Witowski, Jr.</u>		<u>Bethesda 14, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/25/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>TYSON WHEELER</u>		24a. REC'D BY REGISTRAR <u>1331 E. Montg. Ave.</u> DATE <u>FEB 25 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Rockville, Md.</u> <u>Charles L. Hines</u>	

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2290

5

Blank form with faint horizontal lines and vertical columns for data entry.

1



2291

## Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <span style="float: right;"><b>MARYLAND</b></span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <b>Florida</b> <span style="float: right;">b. COUNTY</span>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EauGallie 7,</b> <span style="float: right;"><b>48x-3</b></span>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>110 North Oak Drive</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Leslie Ann Thompson</b>		<b>4. DATE OF DEATH</b> <b>February 19 1960</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>September 5, 1946</b>
<b>9. AGE</b> (In years last birthday) <b>13</b> yrs.		<b>10. IF UNDER 1 YEAR</b> <b>19</b> Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None (Student)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Massachusetts</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>Dan F. Thompson</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Geraldine Brown</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	
<b>INFORMANT</b> <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Cardiac failure</b> <b>754.2</b> <b>DUE TO</b> <b>Operative repair of Ventricular septal defect</b> <b>30 hours</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that I attended the deceased from</b> <b>February 6, 1960</b> , <b>to</b> <b>February 19, 1960</b> , <b>that I last saw the deceased alive on</b> <b>February 19, 1960</b> , <b>and that death occurred at</b> <b>9:34 P. M.</b> , <b>from the causes and on the date stated above</b> <b>ADDRESS</b> (Street, city or town, state) <b>The Clinical Center</b> <b>DATE SIGNED</b> <b>2-20-60</b> <b>ACTUAL SIGNATURE</b> <b>Roland Folse,</b> <b>M.D.</b> <b>National Institutes of Health</b> <b>PHYSICIAN'S NAME (Type)</b> <b>Roland Folse, M.D.</b> <b>Bethesda 14, Maryland</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>RURAL</b>	<b>22b. DATE THEREOF</b> <b>2-23-60</b>	<b>22c. NAME OF CEMETERY OR CREMATORY</b>	<b>22d. LOCATION</b> (City, town, or county) (State) <b>EAU GALLIE FLA.</b>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Rivoli Funeral Home</b> <b>ADDRESS</b> <b>816 H St. NE Wash DC</b>		<b>24b. REC'D BY REGISTRAR</b> <b>DATE</b> <b>FEB 23 '60</b>	<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Howard</b>

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

2291

Florida

13 days

13 days

The Clinical Center, Bethesda, Md., 10 North Oak Drive

Death

Female White

September 2, 1915

Home (Standard)

Home

Manassas, Va.

John P. Thompson

Donaldine Brown

The Clinical Center, Bethesda, Md., 10 North Oak Drive

Charles Talbot

Complete report of attending hospital doctor

February 12, 1916

The Clinical Center  
National Institute of Health  
Bethesda, Md., Maryland

John P. Thompson, M.D.

2160

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washi. D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>		d. STREET ADDRESS <u>1760 Euclid ST N.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Edith Waugh Turnley</u>		4. DATE OF DEATH Month <u>2</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-21-04</u>
9. AGE (In years lost birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>55</u> Days <u>55</u>	IF UNDER 24 HRS. Hours <u>55</u> Min. <u>55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>United States</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Albert Russell Doss</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Bryant</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>226-18-7269</u>	
17. INFORMANT <u>Edwin R. Turnley</u>		Address <u>1760 Euclid St N.W. apt 205 (Son)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MESENTERIC THROMBOSIS</u> 570.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>7 DAYS</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>EXTERIORIZATION OF CECUM 1/26/60, RESECTION JEJUNUM, ILEUM, PORTION ASCENDING COLON 2/2/60</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/11</u> , 19 <u>60</u> , to <u>2/2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/2</u> , 19 <u>60</u> , and that death occurred at <u>3:55 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David Goldenberg</u> M.D.		ADDRESS (Street, city or town, state) <u>6727 16th St N.W.</u> DATE SIGNED <u>2/2/60</u>	
PHYSICIAN'S NAME (Type) <u>DAVID GOLDENBERG</u>		<u>WASHINGTON, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Feb. 4-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		22d. LOCATION (City, town or county) (State) <u>Lynchburg Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>		ADDRESS <u>300 4th St N.E. Wash DC</u>	
24a. REC'D BY REGISTRAR <u>FEB 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Farris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS  
COUNTY OF DALLAS

1918

Know all men by these presents, that \_\_\_\_\_

of the County of \_\_\_\_\_ State of \_\_\_\_\_

do hereby certify that \_\_\_\_\_

is the true and correct copy of \_\_\_\_\_

as the same appears from the \_\_\_\_\_

records of the \_\_\_\_\_

County of \_\_\_\_\_ State of \_\_\_\_\_

this \_\_\_\_\_ day of \_\_\_\_\_ 1918.

Witness my hand and seal of office \_\_\_\_\_

this \_\_\_\_\_ day of \_\_\_\_\_ 1918.

\_\_\_\_\_  
County Clerk

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Notary Public

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G257 3-1-60 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

02276

2292

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		d. STREET ADDRESS <b>617 Stone Street</b>	

3. NAME OF DECEASED (Type or print) <b>Catherine</b> First <b>Ida</b> Middle <b>May</b> Last <b>Twyman</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>3</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 14, 1910</b>
9. AGE (In years last birthday) <b>49 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	

13. FATHER'S NAME <b>Harry Green</b>		14. MOTHER'S MAIDEN NAME <b>Lillie Windear</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Sister - Helen L. Brunner</b>		Address <b>Southawn Rockville</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetic coma</b> <b>260x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause (b) <b>Hyperglycemia and acidosis</b> DUE TO (c) <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>24 hours</b> <b>unknown</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Tracheobronchitis; toxic nephrosis</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at **1:30 P.M.** from the causes and on the date stated above.

ACTUAL SIGNATURE <b>W. H. Hall</b>	ADDRESS (Street, city or town, state) <b>615 W. Montgomery Ave. Rockville, Md.</b>	DATE SIGNED <b>2/3/60</b>
PHYSICIAN'S NAME (Type) <b>William Hall</b>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/7/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Park Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Shaulen</b>		ADDRESS <b>Rockville, Md.</b>	24a. REC'D BY REGISTRAR <b>FEB 9 '60</b>
		24b. REGISTRAR'S SIGNATURE <b>William H. Hall</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3293

Married

Married

Married

Married

Married

Married

1

Handwritten signature or mark at the bottom left corner.



## 2180 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>26 Rockville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1945 Lewis Avenue</b>		d. STREET ADDRESS <b>1945 Lewis Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>B</b> Last <b>Umstead, Sr</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>28</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/29/98</b>
9. AGE (In years last birthday) yrs. <b>61</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>29</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman-retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Ranier K. Umstead</b>		14. MOTHER'S MAIDEN NAME <b>Zula L. (Unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW 1</b>		16. SOCIAL SECURITY NO. <b>577-03-1338</b>	
17. INFORMANT <b>Richard B. Umstead-son-same as 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY ARTERIOSCLEROSIS</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b> <b>15 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>VIRAL GASTROENTERITIS</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>FEB. 27, 1960</b> to <b>FEB. 28, 1960</b> , that I last saw the deceased alive on <b>FEB. 28, 1960</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Gordon S. Rosenburger</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>310 West Montg. Ave. 29 Feb. 1960</b>	
PHYSICIAN'S NAME (Type) <b>Gordon S. Rosenburger</b>		<b>Rockville, MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/3/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>MAR 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2293

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

02278

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. M.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>U.S. Naval Station Hospital</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				d. STREET ADDRESS <b>Lexington Park</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Girl</b> Last <b>VIGIL</b>				4. DATE OF DEATH Month <b>February</b> Day <b>26</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-25-60</b>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months <b>14</b> Days <b>14</b>		IF UNDER 24 HRS. Hours <b>14</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Joe Vigil</b>				14. MOTHER'S MAIDEN NAME <b>Linda M. JOHNS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Joe Vigil</b> Address <b>(Father) Hills Traylor Court, Lexington Park, Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>peritonitis and bowel gangrene</b> <b>560.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ruptured congenital omphalocele</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b> <b>12 hrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prematurity</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>25 February, 1960</b> , to <b>26 February, 1960</b> , that I last saw the deceased alive on <b>26 February, 1960</b> , and that death occurred at <b>6:47A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>JB Avery</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda Md. 2- -60</b>			
PHYSICIAN'S NAME (Type) <b>G.B. AVERY LT MC USN</b>				U.S. Naval Hospital, NNMC, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/29/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST.ALOYSIOUS CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>Leonardtown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mattingley</b>				ADDRESS <b>Senwick St. Leonardtown Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 2 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2181 CERTIFICATE OF DEATH

02279

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
c. LENGTH OF STAY IN 1b <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>26 Rockville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>101 E. Jefferson St.,</b>		d. STREET ADDRESS <b>101 East Jefferson St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>NANNIE</b> Middle <b>S.</b> Last <b>VINSON</b>		4. DATE OF DEATH Month <b>February</b> Day <b>12,</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 18, 1868</b>
9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Montgomery Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John T. Vinson</b>		14. MOTHER'S MAIDEN NAME <b>Rachael Prout</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Albert Bouic, Rockville, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage - Right Hemisphere</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1928</b> , 19 <b>Feb 12</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Feb 11</b> , 19 <b>60</b> , and that death occurred at <b>9:30 A.</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wm. A. Linthicum</b>		ADDRESS (Street, city or town, state) <b>110 S. Washington St. Rockville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Wm. A. Linthicum</b>		DATE SIGNED <b>2/2/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/15/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Rockville, Maryland</b>		24a. REC'D BY REGISTRAR <b>FEB 16 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kenna</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Mont.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>97 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ella</b> Middle <b>Marie</b> Last <b>WALKER</b>				4. DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-3-91</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John ELLIS</b>				14. MOTHER'S MAIDEN NAME <b>Susan KELLY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>INFORMANT (Daughter) Mildred SCHER</b> Address <b>Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>191.5 Carcinomatosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Squamous cell carcinoma</b> DUE TO <b>7 years</b> (c) <b>7 years</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>19 November, 19 59</b> to <b>24 February 1960</b> , that I last saw the deceased alive on <b>24 February</b> , 19 <b>60</b> , and that death occurred at <b>2:40P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C. U. Bramlett</b>				ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda Md.</b> DATE SIGNED <b>2-25-60</b>			
PHYSICIAN'S NAME (Type) <b>C. U. BRAMLETT LT MC USN</b>				U.S. Naval Hospital, NNMC, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-29-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Philadelphia Penn.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Haller</b> ADDRESS <b>Nally 3200 Rhode Island Ave. Mt. Ranier, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 29 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2130

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
c. LENGTH OF STAY IN 1b <b>1 week</b>		d. STREET ADDRESS <b>2106 Hildarose Drive</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3126 Helsel Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRANCES</b> Middle <b>MARY</b> Last <b>WALL</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>12</b> Year <b>19 60</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>June 16, 1897</b>
9. AGE (In years lost birthday) yrs. <b>62</b>		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telephone Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Gov't.</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH FOLK</b>		14. MOTHER'S MAIDEN NAME <b>ELLA BROOM</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>210-12-1541</b>	
17. INFORMANT <b>Mr. Donald R. Wall, 13,304 Ga. Ave.</b>		Address <b>Silver Spring, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA OF BREAST WITH METASTASES</b> DUE TO <b>5 YEARS</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>12 HOURS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HYPERTENSIVE VASCULAR DISEASE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MAY, 1935</b> , to <b>FEB 12, 1960</b> , that I last saw the deceased alive on <b>FEB 12, 1960</b> , and that death occurred at <b>1 P. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7733 ALASKA AVE NW WASH 12 D.C.</b> DATE SIGNED <b>FEB 12 1960</b>			
ACTUAL SIGNATURE <b>Robert L. Krichmar</b> M.D.		PHYSICIAN'S NAME (Type) <b>ROBERT L. KRICHMAR M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/15/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond H. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 16 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2150

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH Jan 15, 1884		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. COLOR White		9. RELIGION Roman Catholic		10. EDUCATION High School	
11. DECEASED AT Home		12. PLACE OF DEATH Baltimore, Md.		13. DATE OF DEATH Jan 25, 1949		14. TIME OF DEATH 10:30 AM		15. CAUSE OF DEATH Myocardial Infarction	
16. DISEASE OR INJURY Coronary Artery Disease		17. PERIOD OF ILLNESS Several weeks		18. PRESENT ILLNESS Chest pain, shortness of breath		19. PREVIOUS ILLNESSES Hypertension, Diabetes		20. MEDICAL HISTORY None	
21. NAME OF PHYSICIAN Dr. J. H. Smith		22. NAME OF HOSPITAL St. Mary's Hospital		23. NAME OF NURSE Mrs. J. H. Smith		24. NAME OF ATTENDING PHYSICIAN Dr. J. H. Smith		25. NAME OF PATHOLOGIST Dr. J. H. Smith	
26. NAME OF CORONER John J. Smith		27. NAME OF JURY None		28. NAME OF JURY None		29. NAME OF JURY None		30. NAME OF JURY None	
31. NAME OF JURY None		32. NAME OF JURY None		33. NAME OF JURY None		34. NAME OF JURY None		35. NAME OF JURY None	
36. NAME OF JURY None		37. NAME OF JURY None		38. NAME OF JURY None		39. NAME OF JURY None		40. NAME OF JURY None	
41. NAME OF JURY None		42. NAME OF JURY None		43. NAME OF JURY None		44. NAME OF JURY None		45. NAME OF JURY None	
46. NAME OF JURY None		47. NAME OF JURY None		48. NAME OF JURY None		49. NAME OF JURY None		50. NAME OF JURY None	
51. NAME OF JURY None		52. NAME OF JURY None		53. NAME OF JURY None		54. NAME OF JURY None		55. NAME OF JURY None	
56. NAME OF JURY None		57. NAME OF JURY None		58. NAME OF JURY None		59. NAME OF JURY None		60. NAME OF JURY None	
61. NAME OF JURY None		62. NAME OF JURY None		63. NAME OF JURY None		64. NAME OF JURY None		65. NAME OF JURY None	
66. NAME OF JURY None		67. NAME OF JURY None		68. NAME OF JURY None		69. NAME OF JURY None		70. NAME OF JURY None	
71. NAME OF JURY None		72. NAME OF JURY None		73. NAME OF JURY None		74. NAME OF JURY None		75. NAME OF JURY None	
76. NAME OF JURY None		77. NAME OF JURY None		78. NAME OF JURY None		79. NAME OF JURY None		80. NAME OF JURY None	
81. NAME OF JURY None		82. NAME OF JURY None		83. NAME OF JURY None		84. NAME OF JURY None		85. NAME OF JURY None	
86. NAME OF JURY None		87. NAME OF JURY None		88. NAME OF JURY None		89. NAME OF JURY None		90. NAME OF JURY None	
91. NAME OF JURY None		92. NAME OF JURY None		93. NAME OF JURY None		94. NAME OF JURY None		95. NAME OF JURY None	
96. NAME OF JURY None		97. NAME OF JURY None		98. NAME OF JURY None		99. NAME OF JURY None		100. NAME OF JURY None	

2295

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>15 Hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>	
3. NAME OF DECEASED (Type or print) First <u>Virg</u> Middle <u>inia</u> Last <u>M.</u> Ward <u>Ward</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>8</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/12/80</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Chestertown, M d.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George Bennett</u>		14. MOTHER'S MAIDEN NAME <u>Florida Hackett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Niece (Mrs. Katherine Sterling)</u>		Address <u>Same as Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Art scler. cerebral vas. disease</u> (c) <u>Hypertensive cardiovascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>59</u> , to <u>Feb 8</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 7</u> , 19 <u>60</u> , and that death occurred at <u>10:22</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Washington D.C.</u> DATE SIGNED <u>2/8/60</u>			
ACTUAL SIGNATURE <u>Robert Young</u>		M.D. <u>  </u>	
PHYSICIAN'S NAME (Type) <u>Robert Young</u>		<u>Wash DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>2-10-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chestertown Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Rd</u>	
24a. REC'D BY REGISTRAR <u>FEB 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1. ~~2~~ ~~3~~ ~~4~~ ~~5~~ ~~6~~ ~~7~~ ~~8~~ ~~9~~ ~~10~~ ~~11~~ ~~12~~ ~~13~~ ~~14~~ ~~15~~ ~~16~~ ~~17~~ ~~18~~ ~~19~~ ~~20~~ ~~21~~ ~~22~~ ~~23~~ ~~24~~ ~~25~~ ~~26~~ ~~27~~ ~~28~~ ~~29~~ ~~30~~ ~~31~~ ~~32~~ ~~33~~ ~~34~~ ~~35~~ ~~36~~ ~~37~~ ~~38~~ ~~39~~ ~~40~~ ~~41~~ ~~42~~ ~~43~~ ~~44~~ ~~45~~ ~~46~~ ~~47~~ ~~48~~ ~~49~~ ~~50~~ ~~51~~ ~~52~~ ~~53~~ ~~54~~ ~~55~~ ~~56~~ ~~57~~ ~~58~~ ~~59~~ ~~60~~ ~~61~~ ~~62~~ ~~63~~ ~~64~~ ~~65~~ ~~66~~ ~~67~~ ~~68~~ ~~69~~ ~~70~~ ~~71~~ ~~72~~ ~~73~~ ~~74~~ ~~75~~ ~~76~~ ~~77~~ ~~78~~ ~~79~~ ~~80~~ ~~81~~ ~~82~~ ~~83~~ ~~84~~ ~~85~~ ~~86~~ ~~87~~ ~~88~~ ~~89~~ ~~90~~ ~~91~~ ~~92~~ ~~93~~ ~~94~~ ~~95~~ ~~96~~ ~~97~~ ~~98~~ ~~99~~ ~~100~~ ~~101~~ ~~102~~ ~~103~~ ~~104~~ ~~105~~ ~~106~~ ~~107~~ ~~108~~ ~~109~~ ~~110~~ ~~111~~ ~~112~~ ~~113~~ ~~114~~ ~~115~~ ~~116~~ ~~117~~ ~~118~~ ~~119~~ ~~120~~ ~~121~~ ~~122~~ ~~123~~ ~~124~~ ~~125~~ ~~126~~ ~~127~~ ~~128~~ ~~129~~ ~~130~~ ~~131~~ ~~132~~ ~~133~~ ~~134~~ ~~135~~ ~~136~~ ~~137~~ ~~138~~ ~~139~~ 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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

28284  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>2296</u> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>5 yr</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5006 Edgemoor Lane</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>57 Bethesda</u> d. STREET ADDRESS <u>5006 Edgemoor Ln</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Rachael S. Webner</u> First Middle Last 4. DATE OF DEATH <u>Feb 16 1960</u> Month Day Year		5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>9-6-1867</u> 9. AGE (In years last birthday) <u>92</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Ill.</u> 11. BIRTHPLACE (State or foreign country) <u>Ill.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>		13. FATHER'S NAME <u>William Simpson</u> 14. MOTHER'S MAIDEN NAME <u>W. Gordon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>no</u> 17. INFORMANT <u>W. Gordon Webner - Son</u> Address <u>2</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>hypertension</u> (a), stating the underlying cause last. (c) <u>hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>2-16-60</u>	
ACTUAL SIGNATURE <u>Frank J. Broschant</u> EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		DATE SIGNED <u>2-16-60</u>	
22a. BURIAL, CREMATION, REBURY (Specify) <u>Cremation</u> 22b. DATE THEREOF <u>2/16/60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u> 22d. LOCATION (City, town, or country) (State) <u>300-4th St. N.E. Wash. D.C.</u>		23. FUNERAL DIRECTOR ADDRESS <u>J. William Lee's Sons Co. 300-4th St. N.E.</u> 24a. REC'D BY REGISTRAR <u>DATE FEB 18 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

NEW YORK STATE DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3298

FILE NO. 100-100000  
100-100000

1. Name of Deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Place of Birth: \_\_\_\_\_

6. Date of Death: \_\_\_\_\_

7. Time of Death: \_\_\_\_\_

8. Cause of Death: \_\_\_\_\_

9. Manner of Death: \_\_\_\_\_

10. Signature of Medical Examiner: \_\_\_\_\_

11. Signature of Coroner: \_\_\_\_\_

12. Signature of Registrar: \_\_\_\_\_

13. Signature of Physician: \_\_\_\_\_

14. Signature of Nurse: \_\_\_\_\_

15. Signature of Other: \_\_\_\_\_

1

FILE NO. 100-100000

2297

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

02285

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>24 min.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>		d. STREET ADDRESS <b>1026 N. Madison Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>WELSH</b>		4. DATE OF DEATH Month Day Year <b>February 3 1960</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-3-60</b>		9. AGE (In years lost birthday) yrs. <b>24</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John F. WELSH</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Ann VENEMAN</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital Records</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hydrops fetalis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Erythroblastosis fetalis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>February 2, 1960</b> , to <b>February 3, 1960</b> , that I last saw the deceased alive on <b>February 3, 1960</b> , and that death occurred at <b>1:33P.M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED		ACTUAL SIGNATURE <b>F. W. Grello</b>		M.D. <b>U. S. Naval Hospital</b>			
PHYSICIAN'S NAME (Type) <b>F. W. GRELLO, LT, MC, USN</b>		Bethesda 14, Maryland		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/9/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Heanson's Funeral Home</b>			
ADDRESS <b>Heanson's Funeral Home</b>		24a. REC'D BY REGISTRAR <b>FEB 9 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		25. I certify that I attended the deceased from _____, to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.		26. I certify that I attended the deceased from _____, to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.		27. I certify that I attended the deceased from _____, to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.		28. I certify that I attended the deceased from _____, to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051244XU2

# CERTIFICATE OF DEATH

28-4

Virginia

Virginia

Sw. Ala.

Alabama (Sw. Ala.)

JOHN M. WOODSON, JR.

U. S. Naval Hospital

Medical

February 3

1940

Unrecorded

1940

Virginia

John

MARGARET ANN VERMAN

JOHN F. WELSH

Hospital Records

John

Virginia Records

Virginia Records

February 3, 1940

February 3, 1940

U. S. Naval Hospital

Virginia

U. S. Naval Hospital

Virginia

Virginia



2298

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>27 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hosp.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>WILSON</b> Last <b>WHITE</b>				4. DATE OF DEATH Month <b>2.</b> Day <b>6</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6.9.1886</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months <b>73</b>		IF UNDER 24 HRS. Days <b>73</b> Hours <b>73</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Public Schools</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>James Alexander White</b>				14. MOTHER'S MAIDEN NAME <b>Jenny S. Smiley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>216-22-1409</b>			
17. INFORMANT <b>Hospital records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hodgkin's Disease</b> 201X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Aug</b> , 19 <b>59</b> to <b>2-6</b> , 19 <b>60</b> and that death occurred at <b>2:15 PM</b> , from the causes and on the date stated above.							22. I lost saw the deceased olive on <b>2-6</b> , 19 <b>60</b>
ADDRESS (Street, city or town, state) <b>Gaithersburg Md.</b>							DATE SIGNED <b>2-6-60</b>
ACTUAL SIGNATURE <b>Dr. Jack Schumacher</b>				PHYSICIAN'S NAME (Type) <b>Dr. Jack Schumacher</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>2/8/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Darnestown Church Cem.</b>	
22d. LOCATION (City, town, or county) <b>Darnestown, Md.</b>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler Funeral Home</b>				ADDRESS <b>1331 E. Montg. Ave. Rockville, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 9 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARY ADAMS STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

2299

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

02287

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>21 Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Patricia</b> Middle <b>Marie</b> Last <b>WHITE</b>				4. DATE OF DEATH Month <b>February</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-12-53</b>	
9. AGE (In years last birthday) <b>6 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John David WHITE</b>				14. MOTHER'S MAIDEN NAME <b>Lelia Marie GIBSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>(F) John D. White, same as #2 above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.5 Congenital Heart Disease (Transposition of Great Vessels)</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>January 31</b> , 19 <b>60</b> , to <b>February 3</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>February 3</b> , 19 <b>60</b> , and that death occurred at <b>4:43 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. E. MC CLENATHAN</b>				ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b>			
PHYSICIAN'S NAME (Type) <b>J. E. MC CLENATHAN, CDR, MC, USN</b>				DATE SIGNED <b>2-4-60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-6-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Monticello Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Charlottesville Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>				24a. REC'D BY REGISTRAR <b>FEB 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

3299

Montgomery

2 Jackson (Hunt)

3 days

Town of Jackson

U. S. Naval Hospital

Proctor

Marie

Walter

Proctor

Commission

12-12-27

John

Marion

John David Miller

John David Miller

John

(1) John D. Miller, born on 12-12-27

January 21

60 2 February 2 60-2

February 2 60

U. S. Naval Hospital

U. S. Naval Hospital, U.S. Navy

Jackson 12, Maryland

Montgomery

Montgomery

John D. Miller, born on 12-12-27, died on 12-12-27, at U. S. Naval Hospital, U.S. Navy, Jackson 12, Maryland.

## 2132 CERTIFICATE OF DEATH

02288

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING 56</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9026 FAIRVIEW ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELSIE</b> Middle <b>(NMI)</b> Last <b>WILLIAMSON</b>		4. DATE OF DEATH Month <b>FEBRUARY 14</b> Day <b>19</b> Year <b>60</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 2, 1868</b>
9. AGE (In years last birthday) <b>91</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>14</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>FRIENDLY, W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>ROBERT WILLIAMSON</b>		14. MOTHER'S MAIDEN NAME <b>REBECCA ELLIS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS. ESTHELENE MORGAN, 9026 FAIRVIEW RD., SILVER</b>		Address <b>SPRING, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Pancreas</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>157X</b> (c) <b>Generalized Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 1, 1956</b> to <b>Feb 14, 1960</b> that I last saw the deceased alive on <b>Feb 14, 1960</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John J. Curry</b> M.D.		ADDRESS (Street, city or town, state) <b>10620 Georgia Ave Silver Spring, Md</b>	
PHYSICIAN'S NAME (Type) <b>JOHN J. CURRY</b>		DATE SIGNED <b>2/14/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>FEB. 17, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ZION HILL CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>TYLER COUNTY, WEST VIRGINIA</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC., SILVER SPRING, MD.</b> <b>Raymond A. Ziska</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 16 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portions. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2948 JGIM



2161

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON SAN.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>IRVING - WOLF</b>				4. DATE OF DEATH <b>FEB-7-1960</b>			
5. SEX <b>MALE</b>	6. COLOR OF RACE <b>Wh.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/6/1901</b>	9. AGE (In years last birthday) <b>58</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>REV.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GROCEER</b>		11. BIRTHPLACE (State or foreign country) <b>LONDON, ENGLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BERNARD WOLKOVITCH</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>098-10-9296</b>		17. ADDRESS <b>1021-QUEBEC TERR. Spg.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>241X</b> DUE TO <b>Bronchial Asthma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Emphysema</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>1 7 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 1, 1960</b> to <b>Feb 7, 1960</b> , that I last saw the deceased alive on <b>Feb 6, 1960</b> , and that death occurred at <b>1:15 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Boris Rabin</b>				ADDRESS (Street, city or town, state) <b>1019 University Boulevard SE 2/7/60</b>			
PHYSICIAN'S NAME (Type) <b>BORIS RABKIN</b>				LOCATION (City, town, or county) (State) <b>Silver Spring Maryland VA.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/9/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>NAT'L MEM PARK</b>		22d. LOCATION (City, town, or county) (State) <b>FALLS CHURCH VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gooding Funeral Home</b>				ADDRESS <b>4217-92nd Ave</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 9 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1881  
101  
CERTIFICATE OF DEATH



*[Faint, mostly illegible text, likely a form for a death certificate. The text is mirrored across the page, suggesting bleed-through from the reverse side.]*

2162

## CERTIFICATE OF DEATH

Reg. Dist. No.

02290

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, DC</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>117 ALBANY AVE</u>		d. STREET ADDRESS <u>632 JEFFERSON NW</u>	
3. NAME OF DECEASED (Type or print) First <u>JENNIE</u> Middle <u>-</u> Last <u>WOLF</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>16</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>?</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>ELI HOROWITZ</u>	
14. MOTHER'S MAIDEN NAME <u>RUTH LEE</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>-</u>	
16. SOCIAL SECURITY NO. <u>578-20-0093</u>		17. INFORMANT <u>LOUIS WOLF</u> Address <u>632 Jefferson NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Cardiac Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Art. Hypertensive Ht. Dis.</u> DUE TO <u>Art. Hypertensive Ht. Dis.</u> (c) <u>Art. Hypertensive Ht. Dis.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec.</u> , 19 <u>59</u> , to <u>Feb.</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb. 16</u> , 19 <u>60</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Isidore Shulman</u> M.D.		ADDRESS (Street, city or town, state) <u>915-19th St. NW</u> DATE SIGNED <u>Feb. 1960</u>	
PHYSICIAN'S NAME (Type) <u>ISIDORE SHULMAN</u>		<u>Wash. D. C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/18/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>OHEV SHOLOM Cem</u>	22d. LOCATION (City, town, or county) (State) <u>DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isidore Shulman</u> ADDRESS <u>4217 9th St NW</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 19 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

108 MIA 130000

STES

CERTIFICATE OF STES

IN BALANCE YEAR OF ANNUAL DEBITMENT OF STES

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MARYLAND STATE DEPARTMENT OF HEALTH MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12291

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>Since 1950</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>2414 EVANS DRIVE</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>2414 EVANS DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>RICHARD A. WOLF</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>29</b> Year <b>19 60</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 30, 1921</b>	
9. AGE (In years last birthday) <b>38</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Repair man, Central office</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>C.&amp;P. Telephone Co.</b>		11. BIRTHPLACE (State or foreign country) <b>PENNA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>ADAM ELMER WOLF</b>				14. MOTHER'S MAIDEN NAME <b>MINNIE MAE GLASS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW #2</b>		16. SOCIAL SECURITY NO. <b>166-12-6172</b>		17. INFORMANT Address <b>Mrs. Wilma J. Wolf, 1222 N. Abington St. Arlington, Virginia</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. BROSCHART</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>FEB. 29, 1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>		22b. DATE THEREOF <b>3/2/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>YORK, PENNSYLVANIA</b>		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 3 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles E. Knaus</b>			

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1001-02

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## 2163 CERTIFICATE OF DEATH

02292

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium &amp; Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fidelphi</i> <i>1673-2</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <i>10523 Deakins Hall Drive</i>	
3. NAME OF DECEASED (Type or print) First <i>Sydney</i> Middle <i>Lynette</i> Last <i>Wolman</i>		4. DATE OF DEATH Month <i>2</i> Day <i>5</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Cauc.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-13-59</i>
9. AGE (In years lost birthday) yrs. <i>1</i>	IF UNDER 1 YEAR Months <i>1</i> Days <i>23</i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>-</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland/Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Benjamin R. Wolman</i>		14. MOTHER'S MAIDEN NAME <i>Mary L. Laurentitz</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Father</i>		Address <i>- same as above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchio litiS-</i> <i>491X</i> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause last. (b) DUE TO (c) <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Congenital Heart Disease. Type - Undet.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>12/13</i> , 19 <i>59</i> to <i>2/5</i> , 1960, that I last saw the deceased alive on <i>2/5</i> , 19 <i>60</i> , and that death occurred at <i>7:25 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Ralph Stiller</i>		ADDRESS (Street, city or town, state) <i>931 Pershing Drive</i>	
PHYSICIAN'S NAME (Type) <i>Ralph Stiller</i>		M.D. <i>md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-7-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Hebrew</i>	22d. LOCATION (City, town, or county) (State) <i>Balto Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis</i>		ADDRESS <i>2100 Ector Place</i>	
24a. REC'D BY REGISTRAR <i>DATE FEB 9 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

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REPORT OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
JANUARY 18, 1903

ALBANY: J.B. LIPPINCOTT & CO. PRINTERS  
1903

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02293

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b. <u>25 HOURS 15 MIN</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SANITARIUM &amp; HOSPITAL</u>		d. STREET ADDRESS <u>3410 Embury St.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARION</u> Middle <u>ROSSELLE</u> Last <u>WOODRING</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-17</u>
9. AGE (in years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life. If retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.I.H.</u>	11. BIRTHPLACE (State or foreign country) <u>MINN.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Sonheim</u>	
14. MOTHER'S MAIDEN NAME <u>Ida <del>Reyna</del> CORNELIA Weeks</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>469-07-0354</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO <u>916.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1st 2nd + 3rd degrees burn involving</u> DUE TO <u>2/3 of body &amp; extremities</u> (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burned at home due to house fire</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7 P.M.</u> o. m. <u>  </u> <u>2-10-1960</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	20f. (City or town) (County) (State) <u>Wheaton MONTGOMERY MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/15/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PIMPHREY, INC.</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 15 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>		DATE SIGNED <u>2-11-60</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## CERTIFICATE OF DEATH

Reg. Dist. No.

02294

2300

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA 57</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		d. STREET ADDRESS <u>6216 GREENTREE RD.</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>H.</u> Last <u>WRIGHT</u>		4. DATE OF DEATH Month <u>2</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-2-1884</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEEL DYE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DAVID HENRY WRIGHT</u>		14. MOTHER'S MAIDEN NAME <u>TEN BROECK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> [If yes, give war or dates of service] <u>1 DAY</u>		16. SOCIAL SECURITY NO. <u>183-103-6593A</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> (c) <u>ARTERIOSCLEROSIS GENERALIZED</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>5 YRS</u> <u>5 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>NOV. 17</u> , 19 <u>59</u> , to <u>FEB 8</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>FEB 7</u> , 19 <u>60</u> , and that death occurred at <u>1:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert G. Angle</u>		ADDRESS (Street, city or town, state) <u>M.D. 5009 DEL RAY AVE., BETHESDA, MD.</u> DATE SIGNED <u>2/8/60</u>	
PHYSICIAN'S NAME (Type) <u>Robert G. Angle</u>		5009 DelRay Ave. Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>		22b. DATE THEREOF <u>2/10/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Sepulchre Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Philadelphia, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Rumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>FEB 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2300

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Time of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Place of death: \_\_\_\_\_

10. Signature of physician: \_\_\_\_\_

11. Signature of registrar: \_\_\_\_\_

12. Date of registration: \_\_\_\_\_



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2134  
CERTIFICATE OF DEATH

Reg. Dist. No.

02295

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2023 LANIER DRIVE</u>		d. STREET ADDRESS <u>2023 LANIER DRIVE</u>	
3. NAME OF DECEASED (Type or print) First <u>ABBIE</u> Middle <u>G.</u> Last <u>YOCUM</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 22, 1877</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>SHAMOKIN, PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LYBRAND HUFMAN</u>		14. MOTHER'S MAIDEN NAME <u>ISABEL POWELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Cora Y. Duhn, 2023 Lanier Dr.</u>		Address <u>Silver Spring, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 20, 1960</u> to <u>Feb. 25, 1960</u> , that I last saw the deceased alive on <u>Feb. 25, 1960</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. B. Little</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>6911 5th St. NW Wash. 12, DC</u>	
PHYSICIAN'S NAME (Type) <u>A. B. LITTLE, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/27/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FOREST OAK CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>GAITHERSBURG, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Pumphrey, Inc.</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>DATE FEB 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>C. S. K. K.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2301

CERTIFICATE OF DEATH

Reg. Dist. No.

02296

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairland</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Fairland Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b> d. STREET ADDRESS <b>9108 Louis Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LEO</b> First <b>XXXXXX</b> Middle <b>F.</b> Last <b>Zwister</b>		4. DATE OF DEATH <b>February 6, 1960</b> Month <b>February</b> Day <b>6</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 13, 1874</b> 9. AGE (In years last birthday) <b>85</b> yrs. <b>5</b> months <b>25</b> days <b>0</b> hours <b>0</b> min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Potomac Elec.</b>	
11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Johanna O-Dekoon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Yes</b>	
17. INFORMANT <b>Daughter</b> <b>4847 Adelard Street</b>		<b>Mrs. Geo. Goetzman- Chevy Chase, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized atherosclerosis</b> DUE TO <b>Diabetes mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>a. 1.</b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec 18, 1959</b> , to <b>Feb 6, 1960</b> , that I last saw the deceased alive on <b>January 17, 1960</b> , and that death occurred at <b>7:52 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1019 University Boulevard E Silver Spring Maryland</b> DATE SIGNED <b>2/6/60</b> ACTUAL SIGNATURE <b>Boris Rabin</b> M.D. PHYSICIAN'S NAME (Type) <b>BORIS RABKIN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-9-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>FEB 9 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

